



## Fibroblast Culturing and Extraction Requisition Form

Allele Diagnostics  
120 N. Pine St, Suite 152  
Spokane, WA 99202  
Phone: 844-255-3532  
Fax: 509-232-5779  
Email: info@allelediagnosics.com

**\*\*Please include a completed requisition for sequencing lab for Allele to send with the specimen.\*\***

### Patient Information

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Sex: ☐ Male ☐ Female ☐ Unknown  
Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

### Specimen Information

Collection date (MM/DD/YYYY): \_\_\_\_\_ Time: \_\_\_\_\_ ☐ am ☐ pm Specimen Source: \_\_\_\_\_

#### Specimen Destination (i.e. sequencing lab)

**PLEASE NOTE: Specimens will be shipped to laboratories/medical facilities with valid U.S. addresses only.**

Institution: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Minimum Amount of DNA Required: \_\_\_\_\_

☐ OK to send DNA extracted directly from tissue (not cultured) if culture is not possible.

*Allele will maintain cultures for 2 weeks after sending out cultured DNA. If you would like us to maintain cultures longer than 2 weeks, or if you expect additional DNA will be needed, please contact our lab.*

### Provider Information

Physician: \_\_\_\_\_ Genetic Counselor: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Institution: \_\_\_\_\_

☐ I would like to be notified when extracted DNA from cultures is shipped via the following contact method:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Billing (complete one section below)

#### ☐ Institutional Bill

Institution: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

#### ☐ Self-Pay\*

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card Number: \_\_\_\_\_ Expiration Month/Year: \_\_\_\_\_ Security Code: \_\_\_\_\_

Card Holder Phone: \_\_\_\_\_ Email/Mailing Address for receipt: \_\_\_\_\_

Credit Card Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(By signing this form, I request and authorize Allele Diagnostics to charge the credit card listed above.)

*\*If payment information does not accompany the sample, the patient must call 844-255-3532 to pay by phone. Specimen processing will be held until a form of payment is provided and a hold is successfully placed on the card for Allele's services.*