APOL1 Requisition Form

Patient: First Name: Last Name:

Referring Physician: First Name: Last Name:

PLACE AN ORDER FOR THE APOL1 TEST

APOL1 Genetics Test Requisition

Please complete only one request per person.

Patient Information

Patient Name
First Name: Last Name:

Date of Birth

MRN#

Sex
•

Collection Information

Date

Collection Time

Phlebotomist Name
First Name: Last Name:

DIAGNOSIS or ICD-10 CODE

Test Information

Test Requested
- APOL1 Genotyping

Tube Types Legend (2 Yellow or Lavender)
-

Referring Physician Information

Referring Physician Name
First Name: Last Name:

Letters
-

Provider NPI#

Institution

Institution Address

Referring Physician Phone Number

Referring Physician Fax

Referring Physician Email
_____

The *APOL1* genetic test is provided for a fee of $395. Submitting this requisition form acknowledges your responsibility for the total payment of the genetic test. This amount should not be reimbursed at the Medicare rate as this charge should not be submitted to insurance companies nor will patients be billed directly. Request for testing and payment must be fulfilled by a clinical entity. An invoice cannot be sent directly to a patient.

Is the billing information the same as the referring physician?

Billing Contact Name
First Name: Last Name:

Billing Contact Email

_____

Billing Address

Billing Phone

Specimen and Shipping Requirements

Acceptable specimens include:

Potential living donors and patients (results provided within 7 days of receiving the samples)

Peripheral blood: At least 2 Lavender top (EDTA) tubes or Yellow top (ACD-A) tubes. Shipped overnight at room temperature.

Please ensure the mailer meets all IATA and DOT requirements for shipping of diagnostic specimens through FedEx or UPS.

Please email us at hlalab@wakehealth.edu to discuss specimen requirements for deceased donors and rapid genetic testing (same business day).

All samples must have two patient identifiers, specifically the patient's name and date of birth. Each sample must be accompanied by a printed copy of this completed requisition form, which you will receive by email after submitting. The ordering provider must agree to the terms of agreement outlined below.

Sample with a printed copy of the completed requisition form should be shipped to:

HLA/Immunogenetics Laboratory
145 Kimel Park Drive, Suite 250
Winston-Salem, NC 27103

Please contact HLA/Immunogenetics Laboratory at +1-336-716-4456

How would you like to receive your results?

Send results via:

-

Email results to:

_____

Terms of Agreement

Contact Name
First Name: Last Name:

Contact Email
_____

Terms of Agreement
- I certify that the above facts are true to the best of my knowledge and hereby submit the above information to the HLA/Immunogenetics Laboratory at Wake Forest Baptist Medical Center.

Terms accepted on date

PLEASE FAX OR EMAIL THIS FORM TO: hlalab@wakehealth@edu or (336) 774-7665