RPRD DIAGNOSTICS
— Right Patient | Right Drug —

# TEST REQUISITION FORM

**Include completed form with your samples. Send order inquiries to orders@rprdx.com.**

**Shipping address**
RPRD Diagnostics, LLC
1225 Discovery Parkway, Suite 260
Milwaukee, WI 53226

## PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

DOB (mm/dd/yyyy) _____ MRN _____ Gender _____

☐ Informed Consent filed (if applicable for your state)
☐ Report incidental findings to my doctor if medically actionable (as determined by the Medical Director at RPRD)
☐ Consent for use of de-identified data for research

## REQUESTED PGX TESTS

☐ **Whole Pharmacogenomics Scan (WPS™)**
☐ **CNT Panel (CEP72, NUDT15 and TPMT)**
☐ **NT Panel (NUDT15 and TPMT)**
☐ **NUDT15**

## SPECIMEN INFO

Collection date (mm/dd/yy) _____
Collection time _____

| | |
|---|---|
| Specimen type | ☐ Whole Blood (collect peripheral blood in EDTA tube, 3-5ml) |
| | ☐ Saliva (Oragene Dx; # OGD-500) |
| | ☐ Other (contact us):_____ |
| Submitter ID _____ | RPRD ID (Internal use only) _____ |

## ORDERING PROVIDER INFORMATION

Department _____ Institution name _____

Street Address _____

City _____ State _____ Zip code _____

Phone _____ Fax _____

Provider First Name _____ Provider Last Name _____

Email Address _____ NPI # _____

## AUTHORIZATION

By completing this order, I certify that either I am the ordering provider, or I am authorized by an ordering provider to order this test, or I am authorized under applicable state law to order this test. I further certify that I have conveyed all required information to the patient (or legal guardian) and have obtained his or her consent for this test order. I agree to RPRD Diagnostics' terms of service and privacy policy.

Ordering provider signature _____ Date (mm/dd/yy) _____

## INSTITUTIONAL BILLING INFORMATION

RPRD Diagnostics will send invoice to the institution address above or the one on file. For further billing questions contact us at billing@rprdx.com.

**CLIA # 52D2126222**

## INFORMATION ABOUT SPECIMEN COLLECTION, HANDLING AND SHIPPING REQUIREMENTS

| TEST NAME | SPECIMEN TYPE | | | | | | TURNAROUND TIME* |
|---|---|---|---|---|---|---|---|
| | Whole blood | Saliva | gDNA | Fresh frozen tissue | Buccal swab | Other | |
| **WPS™** | ✪ | ■ | ∞ | ⊘ | ⊘ | ∞ | 4-6 weeks |
| **CNT Panel** | ✪ | ■ | ∞ | ⊘ | ⊘ | ∞ | 5 days |
| **NT Panel** | ✪ | ■ | ∞ | ⊘ | ⊘ | ∞ | 5 days |
| **NUDT15** | ✪ | ■ | ∞ | ⊘ | ⊘ | ∞ | 5 days |

**KEY**
✪ **Preferred**
■ **Accepted**
∞ **Contact us**
Tel: (414) 316-3097
E-mail: orders@rprdx.com
⊘ **Not accepted**
* Test results are reported Monday through Friday.

| | |
|---|---|
| **Whole Blood** | Collect 3 – 5ml of peripheral whole blood in EDTA tube. Specimens with < 3ml will be considered "precious" and processed with no guarantee of results. Blood sample may be rejected if frozen, hemolyzed, or clotted. |
| **Saliva** | Collect using Oragene•Dx (OGD-500) DNA collection kit according to manufacturer's instructions. |
| **gDNA** | Please contact RPRD for processing of Genomic DNA (gDNA) specimens. Specimens will be assessed by standard quality assurance (QA) methods. Additional information and/or material may be requested if QA standards are not met. |

| SPECIMEN SUBMISSION/TEST REQUISITION FORMS | |
|---|---|
| **1** | Please label all specimen containers with the patient full name (first and last name) plus at least one additional unique identifier, including:<br>• Date of birth<br>• Medical record number<br>• Date of collection |
| **2** | Identical information must be provided between the specimen collection tube(s) and the submitted requisition form |
| **3** | All fields except the "Internal use only" are required in the form. Please understand an incomplete form may cause delay in the sample processing and result in longer turnaround time. Additional copies of the form are available at www.rprdx.com. |
| **4** | Please contact us if a patient has previously ordered a test from RPRD Diagnostics. We can use banked specimens to process new orders, thus avoiding additional collection and shipping fees. |
| **5** | Billing is institutional ONLY. Please provide complete institutional billing information on the test requisition form. For further billing questions contact us at billing@rprdx.com. |
| **6** | Please contact us if you require an individualized clinical report for your patient. Please submit the patient's medication list in electronic format (e.g., Excel, .txt, .csv, etc.) to orders@rprdx.com. |

| SHIPPING AND HANDLING INSTRUCTIONS | |
|---|---|
| **1** | Specimens should be shipped Sunday through Thursday FedEx Priority Overnight or UPS Next Day Air. If a weekend delivery is necessary, please contact us to make special arrangements. |
| **2** | Specimens must maintain ambient temperature during transport; we recommend insulated shipping containers. During hot weather, include a frozen ice pack in the shipping container. Specimens should never freeze. |
| **3** | Whole blood and saliva specimens must be received by RPRD Diagnostics, LLC within 7 days from time of collection to ensure specimen stability and quality. |
| **4** | DOT and IATA requirements for proper shipping labeling of diagnostic specimens includes:<br>• Placing specimen in a leak-proof secondary vessel.<br>• Place absorbent material between the primary and secondary packaging.<br>• An itemized list of contents must be enclosed between the secondary packaging and the outer packaging.<br>Package and Air Waybill must show text: "Diagnostic Specimen" and labeled with UN3373 designation. |
| **5** | All delivery carriers (local and non-local) deliver directly to our office suite. We receive samples during our business hours - 7AM to 4PM CST. |
| **6** | Holiday schedules will be posted on our website at least one week prior to major holidays; existing customers will also receive e-mail notification of schedule changes. |

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