



Neuberg
DIAGNOSTICS

**CENTER FOR
GENOMIC
MEDICINE**

TEST REQUISITION FORM

CHIMERISM ANALYSIS

(Please fill this requisition form separately for patient and donor)

Please select, this sample is for Patient Donor

Name _____

DOB DD MM YYYY Age _____ Gender _____

Sample Information:

Collection Date DD MM YYYY Collection Time _____ AM / PM

Place of Collection _____ Collected By _____

Test to be performed :

Chimerism Study (Pre Post)

Split Cell Chimerism Study (T-cells)

Please specify name of patient, if this sample is of donor _____

Please specify name of donor, if this sample is of patient _____

Patient and Donor are Blood Related Unrelated

If related, please mention relationship _____

Patient medical information :

Medical Diagnosis (specify) _____

Did the patient receive blood products (ever) ? Yes No Unknown Date last received _____

Note : The samples must reach the lab within 12-24 hours of collection

Signature of Clinician

Consent

I have had the opportunity to ask questions to my healthcare provider regarding this test, including the reliability of test results, the risks and the alternatives prior to giving my informed consent.

I have read and understood/have been explained the above in a language of my understanding and permit NCGM to perform the recommended genetic analysis

I understand that the data derived from my genetic testing may be stored indefinitely as a part of the laboratory database. This data is always stored in de-identified form. I understand my de-identified data/sample may be used for research collaborations as well as scientific presentations and publications

Signature of Patient/Donor

Neuberg Center for Genomic Medicine (NCGM)