Bloodworks Labs
LABORATORY SERVICES

REQUEST FOR TESTING

Bloodworks Eastlake Bleeding Disorders Laboratory
1551 Eastlake Ave E, Suite 100 | Seattle, WA 98102
Phone 206- 568-2184 | **Fax** 866-560-0806
Laboratory Staffed Monday-Friday

DNA TESTING

3250-05 ☐ DNA/Factor VIII Inversion;
☐ reflex to 3250-02

3250-02 ☐ DNA Hemophilia A Mutation Evaluation

3250-11 ☐ Genotyping for known Hemophilia/VWD Mutation

3250-10 ☐ DNA Hemophilia B Mutation Evaluation

3250-08 ☐ DNA von Willebrand Disease Type 2A/2B/2M;
☐ reflex to 3250-17

3250-09 ☐ DNA von Willebrand Disease Type 2N;
☐ reflex to 3250-17

3250-17 ☐ DNA von Willebrand Disease Evaluation

SAMPLE INSTRUCTIONS

Whole Blood Samples-

- DNA mutation testing requires at least 3 ml EDTA whole blood (purple top).
- Samples must arrive at Bloodworks within 72 hours after collection shipped preferably with a “cool pack.”
- Samples may be sent via overnight express
- **Samples arriving after 1 pm on Friday are not acceptable**

Cultured Amniocytes Samples-

- Two T-25 flasks of cells cultured to confluency
- Specimens must be sent via overnight courier
- **Bloodworks does not have facilities to culture amniocytes.**

SHIPPING INSTRUCTIONS

For Whole Blood Samples:

- Samples must arrive within 72 hours after collection
- Ship with a “cool pack”
- Send to address below

Bloodworks
Attn: Eastlake Genomics Laboratory
1551 Eastlake Ave E. Suite 100
Seattle, WA 98102

For Cultured Amniocyte Samples:

- Collect Two T-25 flasks of cells cultured to confluency
- Ship via an overnight courier
- Send to address below:

Bloodworks
Attn: Genomics Lab
921 Terry Ave
Seattle, WA 98104.

Note: Any testing sample that arrives after 1 pm on Fridays are not acceptable

Submitting laboratory is responsible for obtaining consent for genetic testing per state law. **New York State Patients only:** Check the box confirming consent was obtained. ☐

SPECIMEN INFORMATION: Fill in ALL of Fields Below

Collection Date: DATE ______ /______/ ______ TIME_____________ ☐ **am** ☐ **pm**

*Drawn By:*____

*History/Comments/Special instructions*______________________________

____

Factor activity/Diagnosis/Purpose of Testing:

____

ICD10 Code____

PATIENT NAME:

LAST	***FIRST***	***M.I.***
Hospital		
Medical Record #	***Sex (M/F)***	***Date of Birth (mm/dd/yy)***

PHYSICIAN NAME **or authorized person ordering test**

Last____________________**First**____________________

Phone____________________ **Pager:**____________________

Contact Person____________________ **Phone**________________

SEND BILLING / REPORT TO:

Fax: ____

Name: ____

Street: ____

City, State, Zip: ____

*Name*____

*Street:*____

*City, State, Zip*____

If the specimen is from an individual other than the affected patient:

Affected person’s name:______________________________

Relationship to the Patient:______________________________