

# HEALTH GENETIC CENTER

2175 Keele St., Toronto, ON M6M 3Z4, Canada  
 Phone: 1-866-362-0577 Fax: 416-658-2042

Form HGC-SF112604

|                          |                    |                            |
|--------------------------|--------------------|----------------------------|
| Date                     | Account            | Lab No                     |
| PMT                      | BV .CG .CSH MO CHD | S                          |
| SHP CN CA US PU NO Other | SAMPL              | BL BV FC CR FT TS UR Other |

## DNA TEST REQUISITION FORM

### PHYSICIAN/PRACTITIONER:

Dr.: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Clinic: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 City: \_\_\_\_\_ Province/State: \_\_\_\_\_  
 P.Code/ZIP: \_\_\_\_\_ Country: \_\_\_\_\_ Signature: \_\_\_\_\_

### PATIENT:

Name / ID: \_\_\_\_\_ Sex:  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy)

### DNA PROFILES:

**DP515 - Atherosclerosis DNA Profile:**

*Chlamydia pneumoniae*, Human Herpesvirus 6, *Helicobacter pylori*, *Mycoplasma* spp. (*M. pneumoniae*, *M. fermentans*, *M. hominis*, *M. penetrans*), *Nanobacterium* spp.  
 Samples: Whole blood (5ml) in lavender EDTA tube

**DP513 - Chronic Asthma DNA Profile:**

*Aspergillus* spp., *Chlamydia pneumoniae*, *Mycoplasma* spp. (*M. pneumoniae*, *M. fermentans*, *M. hominis*, *M. penetrans*), *Staphylococcus aureus*, *Legionella* spp.  
 Samples: Whole blood (5ml) in lavender EDTA tube  
 Sputum specimen or throat swab in sterile container  
 Bronchial washing or bronchoalveolar lavage in sterile container

**DP521 - Chronic Depression DNA Profile:**

Borna Disease virus, *Chlamydia* sp. (*C. pneumoniae*, *C. psittaci*), Human herpesvirus 6, *Mycoplasma* spp. (*M. pneumoniae*, *M. fermentans*, *M. hominis*, *M. penetrans*)  
 Samples: Whole blood (5ml) in lavender EDTA tube

**DP501 - Chronic Fatigue Syndrome DNA Profile:**

*Aspergillus* spp., *Chlamydia* spp. (*C. pneumoniae*, *C. psittaci*), *Candida albicans*, Cytomegalovirus, Human herpesvirus 6, *Mycoplasma* spp. (*M. pneumoniae*, *M. fermentans*, *M. hominis*, *M. penetrans*)  
 Samples: Whole blood (5ml) in lavender EDTA tube

**DP523 - Chronic Prostatitis DNA Profile:**

*Chlamydia* spp. (*C. pneumoniae*, *C. trachomatis*), *Mycoplasma* spp. (*M. pneumoniae*, *M. genitalium*), *Trichomonas vaginalis*, *Ureaplasma urealyticum*  
 Samples: Urethral swab  
 Urine sample (8ml) in sterile container

**GP533 - Crohn's Disease Predisposition DNA Profile:**

R702W mutation, G908R mutation, M1007fs mutation  
 Samples: Whole blood (5ml) in lavender EDTA tube

**DP519 - Rheumatoid Arthritis DNA Profile:**

*Chlamydia* spp. (*C. pneumoniae*, *C. trachomatis*, *C. psittaci*), Cytomegalovirus, Human herpesvirus 6, *Mycoplasma* spp. (*M. pneumoniae*, *M. fermentans*, *M. hominis*, *M. penetrans*)  
 Samples: Whole blood (5ml) in lavender EDTA tube  
 Synovial fluid in sterile container

**DP517 - Sexually Transmitted Diseases DNA Profile:**

*Chlamydia trachomatis*, *Haemophilus ducreyi*, *Mycoplasma* spp. (*M. pneumoniae*, *M. genitalium*), *Neisseria gonorrhoeae*, *Trichomonas vaginalis*  
 Samples: Male - Urethral swab and urine sample in sterile container  
 Female - Endocervical swab and urine sample in sterile container

**DP531 - Tick-Borne Pathogens DNA Profile:**

*Borrelia burgdorferi* (Lyme Disease), *Babesia* spp., *Ehrlichia* spp., *Bartonella* spp.  
 Samples: Whole blood (5ml) in lavender EDTA tube  
 Urine sample (8ml) in sterile container

### INFECTIOUS DNA TESTS:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> D116 - <i>Aspergillus</i> spp.                    | <input type="checkbox"/> D106 - <i>Chlamydia psittaci</i>    | <input type="checkbox"/> D140 - <i>Histoplasma capsulatum</i>                          | <input type="checkbox"/> D152 - <i>Mycoplasma</i> spp.        |
| <input type="checkbox"/> D118 - <i>Babesia</i> spp.                        | <input type="checkbox"/> D108 - <i>Chlamydia pneumoniae</i>  | <input type="checkbox"/> D142 - Human herpesvirus 6                                    | <input type="checkbox"/> D160 - <i>Nanobacterium</i> spp.     |
| <input type="checkbox"/> D120 - <i>Bartonella</i> spp.                     | <input type="checkbox"/> D110 - <i>Chlamydia trachomatis</i> | <input type="checkbox"/> D144 - Human papillomavirus (HPV)                             | <input type="checkbox"/> D154 - <i>Neisseria gonorrhoeae</i>  |
| <input type="checkbox"/> D122 - <i>Blastomyces dermatitidis</i>            | <input type="checkbox"/> D130 - Cytomegalovirus              | <input type="checkbox"/> D146 - <i>Legionella</i> spp.                                 | <input type="checkbox"/> D156 - <i>Staphylococcus aureus</i>  |
| <input type="checkbox"/> D124 - Borna Disease virus                        | <input type="checkbox"/> D132 - <i>Ehrlichia</i> spp.        | <input type="checkbox"/> D148 - <i>Leptospira</i> spp.                                 | <input type="checkbox"/> D112 - <i>Toxoplasma gondii</i>      |
| <input type="checkbox"/> D126 - <i>Borrelia burgdorferi</i> (Lyme Disease) | <input type="checkbox"/> D134 - Epstein-Barr virus           | <input type="checkbox"/> D150 - Methicillin-resistant <i>Staphylococcus</i> spp. (MRS) | <input type="checkbox"/> D114 - <i>Trichomonas vaginalis</i>  |
| <input type="checkbox"/> D128 - <i>Candida albicans</i>                    | <input type="checkbox"/> D136 - <i>Haemophilus ducreyi</i>   |  | <input type="checkbox"/> D158 - <i>Ureaplasma urealyticum</i> |
|  | <input type="checkbox"/> D138 - <i>Helicobacter pylori</i>   |  |   |

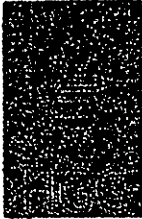
### PATIENT CONSENT AGREEMENT

I, the undersigned, wish to have DNA testing done, the purpose of which is to attempt to determine possible infectious pathogens. This testing is intended to be only used as a research to provide a physician with additional information about my medical conditions. The results will be reported to the physician and must be interpreted along with physical examination and/or diagnostic findings.  
 I agree to hold harmless, indemnify and defend Health Genetic Center, its agents, servants, officers, and employees, and persons drawing blood or taking tissue samples, of and from any and all claims arising out of any allegation concerning the testing. Health Genetic Center has not been advised of any use intended for the results, nor of any actions contemplated to be taken based on the results, nor of the identities of any person to whom I intend to distribute or publish the results.  
 I understand and agree to the practices, policies and fees set out by Health Genetic Center.

Full Legal Name (Please, print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### NOTES/REQUESTS:

Please submit white copy with samples and keep yellow copy for your records



# Health Genetic Center

2175 Keele St., Toronto, ON M6M 3Z4, Canada  
Phone: 1-888-382-0577 Fax: 416-658-2042  
Web: www.dna-human.com

Dear Valued Client,

Thank you for taking the time to do DNA Infection Disease Testing. In order to have your sample processed as soon as possible, we ask that you please fill out the following to allow for a smoother payment transaction.

**Payment:**

*Payment methods*

**Money Order / Certified Check.** Please make it payable to *Health Genetic Centre.*

**PayPal.** Please make payment to *paypal@forensicgeneticscenter.com*

o Payment sent from email address:

\_\_\_\_\_

o PayPal Transaction ID: \_\_\_\_\_ Date of Purchase:

\_\_\_\_\_

**VISA / MasterCard / AmEx.** Please complete and submit *Credit Card Authorization* (see below).

Card Type: VISA MasterCard American Express

Card Number: Expiration Date: \_\_\_\_ / \_\_\_\_

Name on card: \_\_\_\_\_

Address on statements:

\_\_\_\_\_

I agree to pay the total amount according to *Card Issuer Agreement (Merchant Agreement in Credit Voucher).*

Signature: \_\_\_\_\_

*(payment cannot be processed without a signature)*

Regards,  
Billing Department  
Health Genetic Center



# Laboratory Requisition - Contract Service

This requisition form, when completed, constitutes  
a referral to MDS Metro laboratory physicians

LifeLabs Laboratory Services  
3680 Gilmore Way Burnaby BC V5G 4V8  
Tel: 604 431 5005 Fax: 604 412 4444

|   |  |  |
|---|--|--|
| <b>Client Summary Label</b>   | <b>Test Summary Label</b>              | <b>Demographic Label</b>   |
| <b>Account #: A1769 Name: LifeLabs Health Services</b>  |  |  |
| <b>Patient Name</b>   | <b>Date of Birth</b><br>Day Month Year | <b>Gender</b><br><input type="checkbox"/> Female <input type="checkbox"/> Male |
| <b>Ordering Physician Name and MSC Number</b><br><b>Clinical Trial 90008CLI</b>   | <b>Specimen Collected by:</b>          | <b>Date and Time</b>   |
| <b>Fasting</b> <input type="checkbox"/> No <input type="checkbox"/> Yes -      hours  | <b>Diagnosis/Comments:</b>             |  |
| <b>Designated Collection Site(s):</b>   |  |  |
| <b>Test or Services Requested</b>   |  |  |
| <b>National Client Name:</b> Paragon Genetics<br>(enter on billing screen – Statement info field)   |  |  |
| <b>Test Mnemonics:</b> REFO<br>CANFEE   |  |  |
| <b>Service Required:</b> Infectious Collection  |  |  |
| <ul style="list-style-type: none"><li>▪ Patient will not be presenting with a kit – use your own supplies</li><li>▪ Collect 5 ml whole blood in EDTA tube. No processing required.</li><li>▪ Label tube with patient’s full name, date of birth, date and time of collection.</li></ul> |  |  |
| Ship at room temperature to Paragon using BRL FedEx account number.   |  |  |
| Paragon Genetics<br>2175 Keele St.<br>Toronto, Ontario<br>M6M 3Z4<br>Ph: 416-658-2041   |  |  |
| <b>Signature</b>  | <b>Date:</b>                           |  |