HEALTH GENETIC CENTER

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

Form HGC-SF112004

For Office Use Only	Date		Account		Lab No	
	PMT	MV · CC · CSH MO CHQ	#		$	
SHP	ON CA US PU NO Other	SMPL	BL SW 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 spp.(*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:

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

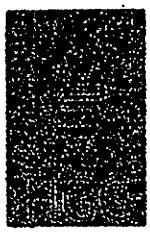
PATIENT CONSENT AGREEMENT

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: 1-866-382-0577 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*
  - Payment sent from email address: _____
  - 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

Client Summary Label	Test Summary Label	Demographic Label

Account #: A1769 Name: LifeLabs Health Services

Patient Name	Date of Birth Day Month Year	Gender ☐ Female ☐ Male

Ordering Physician Name and MSC Number	Specimen Collected by: Date and Time
Clinical Trial 90008CLI	
Fasting ☐ No ☐ Yes - hours	Diagnosis/Comments:

Designated Collection Site(s):

Test or Services Requested

National Client Name: Paragon Genetics
(enter on billing screen – Statement info field)

Test Mnemonics: REFO
CANFEE

Service Required: Infectious Collection

- Patient will not be presenting with a kit – use your own supplies
- Collect 5 ml whole blood in EDTA tube. No processing required.
- Label tube with patient's full name, date of birth, date and time of collection.

Ship at room temperature to Paragon using BRL FedEx account number.

Paragon Genetics
2175 Keele St.
Toronto, Ontario
M6M 3Z4
Ph: 416-658-2041

Signature	Date: