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TEST REQUISITION FORM

Laboratory Director: Dorothy Wong, M.D.
CLIA Number: 05D2048075

1. TEST ORDERED

Check one box to order test:

☐ **AvaGen Test for Keratoconus Risk Factor and Corneal Dystrophies**

☐ **Universal Test for Corneal Dystrophy:** Includes *Granular Corneal Dystrophy type 1 (GCD1) and Granular Corneal Dystrophy type 2 (GCD2), Lattice Corneal Dystrophy type 1 (LCD1), Reis-Bucklers Corneal Dystrophy (RBCD), and Thiel-Behnke Corneal Dystrophy (TBCD).*

2. ACCOUNT INFORMATION

Clinic Name:

Address:

City: State: ZIP:

U.S.

Phone Number: Ordering Physician Email:

Signature of Ordering Physician

I, the physician named herein, confirm that I am requesting the test identified in box #1 above. The report is confidential, and results will be used with standard clinical assessments to guide patient care decisions. To the extent the patient shows clinically actionable findings, and the patient authorizes consent in Section 4 below, test results may be shared with a genetic counselor.

Name (Ordering Physician): **Signature:**

3. SAMPLE COLLECTION INFORMATION

Collection Date:

MM / DD / YYYY

Storage Condition from Clinic Collection until Shipment:

☐ Room Temperature ☐ Refrigeration ☐ Frozen

Patient Clinical Diagnosis: ☐ Keratoconus ☐ Keratoglobus ☐ Pellucid Marginal Degeneration
☐ Post Refractive Surgery Ectasia ☐ Corneal Dystrophy ☐ Unknown ☐ Other(describe in Comments)

Comments:

4. PATIENT INFORMATION AND INFORMED CONSENT

Patient Identification Number or Name:

Sex:
☐ Male
☐ Female

Date of Birth:

MM / DD / YYYY

Patient Email:

Patient State of Residence:

Avellino Lab USA (Avellino) will facilitate genetic counseling for patients whose results show clinically actionable findings at no additional charge. Results may be reported to the designated physician(s) as well as a genetic counselor. By signing below, I agree and acknowledge that (i) I have read and understand the information provided on this form and have had an opportunity to have any questions answered by my healthcare provider; (ii) I give permission for Avellino to have my results reported to a genetic counselor to the extent results are clinically actionable. For information on Avellino's privacy practices, see www.avellino.com/genetic-data-policy

Name of Patient or Person Authorized to Consent (Print): _____

Signature of Patient or Person Authorized to Consent: _____ Date: _____

5. AVELLINO INTERNAL USE ONLY

Inspection by (Initials/ Date): _____

Receipt time frame acceptable? ☐ Yes ☐ No

Sample labeled correctly? ☐ Yes ☐ No

Sample within expiration? ☐ Yes ☐ No

Storage condition acceptable? ☐ Yes ☐ No

Other _____