GRANGER GENETICS

ASPARAGINASE REQUISITION FORM

601 Biotech Drive, Suite 301
North Chesterfield, VA 23235
PHONE: (844)347-2643; FAX: (804)977-5041
Email: clientservices@grangergenetics.com

PATIENT INFORMATION

Last Name* First Name* M.I.

Street Address

City State Zip Code

DOB*: _____

SEX*: Male ☐ Female ☐

MRN #: _____

Sample ID: _____

PO# if Required: _____

*Indicates Required Field

**See specimen requirements on the back of the page

*** *PLEASE NOTE: Granger Genetics is closed and does not receive samples on Saturday or Sunday, please plan your shipments accordingly.*

PRACTITIONER & INSTITUTION BILLING INFORMATION

Institution Name: Allina Health Cancer Institute

Ordering Practitioner*: _____

Ordering Practitioner's Signature on this line. Copies of Electronic Orders can be sent in lieu of actual wet signature.

Billing and Report to:

Billing Address: Allina Health Laboratory
Referral Department
PO Box 342 Mail Route 20203
Minneapolis, MN 55440-0342

Phone: (p) 612-863-4356 Fax: (f) 612-863-3186

Email: CENLabSendouts@allina.com

SEND DUPLICATE REPORT TO:

Name Fax Number

SAMPLE INFORMATION

Date of Collection*: _____ Time of Collection: _____ AM / PM

Did the patient receive a previous dose of asparaginase? (Y/N) _____

If Yes Date of last Injection: _____ Time of last Injection: _____ AM / PM

L-asparaginase administered*: (Please Select One Option)

☐ Asparlas ☐ Erwinaze ☐ Oncaspar ☐ Rylaze ☐ Other _____

PLEASE SELECT A TEST TO BE PREFORMED*

◯ Asparaginase Activity **OR** ◯ Asparaginase Panel (Includes Activity & Antibody)

SAMPLE TUBE LABEL AND/OR COMMENTS

Sent through Allina Health