



Instructions: Send the completed form with the patient specimen to avoid delays in testing and ensure appropriate specimens are submitted.

Patient Information (required)

Patient Name <i>(Last, First, Middle)</i>		Birth Date <i>(mm-dd-yyyy)</i>
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose		Legal/Administrative Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary

Referring Provider Information

Referring Provider Name <i>(Last, First)</i>	Phone	Email
Other Contact Name <i>(Last, First)</i>	Phone	Email

Test Requested

<input type="checkbox"/> BCLL / IGH Somatic Hypermutation Analysis, B-Cell Chronic Lymphocytic Leukemia (B-CLL), Varies <input type="checkbox"/> P53CA / Hematologic Neoplasms, TP53 Somatic Mutation, DNA Sequencing Exons 4–9 , Varies

Specimen Provided

<input type="checkbox"/> Blood (liquid) <input type="checkbox"/> Bone Marrow Aspirate (liquid) (P53CA / Hematologic Neoplasms, TP53 Somatic Mutation, DNA Sequencing Exons 4–9 , Varies) <input type="checkbox"/> Fresh Tissue (P53CA / Hematologic Neoplasms, TP53 Somatic Mutation, DNA Sequencing Exons 4–9 , Varies), specify type: _____

Clinical Information Required – incomplete information will result in **delayed processing and resulting**.

<input type="checkbox"/> Diagnostic sample <input type="checkbox"/> Posttreatment sample
Provide the following information: <input type="checkbox"/> Flow cytometry report or other diagnostic paperwork indicating confirmation of CLL diagnosis and % of B-cells. <input type="checkbox"/> WBC count from a recent CBC or absolute lymphocyte count: _____ <input type="checkbox"/> Other relevant clinical information: _____