PRAXIS GENOMICS

THIS FORM MUST ACCOMPANY ALL SAMPLES

LAB USE ONLY

6115 Peachtree Dunwoody Rd, Suite 220 | Atlanta, GA 30328 | Phone: 678-837-4022 | Testing information available at www.praxisgenomics.com

HEREDITY TEST REQUEST FORM

Sample 1 Information

Last (Family) Name	First Name	MI	Date of Birth
			____/____/____ MONTH DAY YEAR

Has Individual been previously tested at this facility?

☐ No ☐ Yes, Lab ID# :_____

Specimen Collection Date / Shipping Condition

____/____/____ MONTH DAY YEAR

☐ Room Temperature
☐ Frozen

Sex

☐ Male ☐ Female

Has a Relative been previously tested at this facility?

☐ No ☐ Yes, Praxis ID# :_____

Name:_____

DOB : ____/____/____ MONTH DAY YEAR

Relation to Sample 1: _____

Specimen Source

☐ Whole Blood*
☐ Cultured Cells*, Type _____
☐ Tissue*, Type _____
☐ Saliva
☐ Buccal Swab
☐ Extracted DNA

*Only Whole Blood, Cells or Tissue are acceptable for OGM and Transcriptome testing. Blood samples for Transcriptome testing must be frozen or stabilized in Tempus tubes. See website for details.

LAB USE ONLY

Blood Transfusion / Marrow Transplant

☐ No
☐ Within Last 30 Days, Date and Type

____/____/____ MONTH DAY YEAR Type: _____

Primary Email Address for Report Delivery	Invoice ID

Test Selection

Heredity Testing

☐ (SRG301) Mitochondrial and Y Haplogroup Analysis
☐ (SRG302) Relatedness Testing Duo
☐ (SRG303) Relatedness Testing Trio

Family History / Ethnicity / IVF Details

Prior Genetic Testing	Additional Comments

Billing Information Notice

Payment for testing is handled through an invoice system. The invoice is generated following consultation about the appropriate test to be ordered. Please Include the unique Invoice ID in the **Sample Information** section above. The invoice must be paid in full before samples are processed by Praxis Genomics. Samples received with incorrect or missing invoice information will be delayed or possibly rejected depending on sample collection date. For payment options visit our website at: www.praxisgenomics.com/billing or contact us at 678-837-4022 or support@praxisgenomics.com.

Additional Individuals

Sample 2

Last (Family) Name	First Name	MI	Date of Birth _____ / _____ / _____ MONTH DAY YEAR
	Specimen Collection Date / Shipping Condition _____ / _____ / _____ MONTH DAY YEAR ☐ Room Temperature ☐ Frozen		Sex ☐ Male ☐ Female
Has Individual been previously tested at this facility? ☐ No ☐ Yes, Praxis ID# :_____	Specimen Source ☐ Whole Blood ☐ Cultured Cells, Source _____ ☐ Tissue, Source _____ ☐ Extracted DNA, Source _____ ☐ CVS ☐ Direct Amniotic Fluid **NOTE:** Currently all production testing provided requires Whole blood or Cultured Cells. Praxis Genomics only accepts other sample types for testing for mutually approved research purposes.	LAB USE ONLY Blood Transfusion / Marrow Transplant ☐ No ☐ Within Last 30 Days, Date and Type _____ / _____ / _____ Type: _____ MONTH DAY YEAR	
Relationship to Sample 1, if known			

Sample 3

Last (Family) Name	First Name	MI	Date of Birth _____ / _____ / _____ MONTH DAY YEAR
	Specimen Collection Date / Shipping Condition _____ / _____ / _____ MONTH DAY YEAR ☐ Room Temperature ☐ Frozen		Sex ☐ Male ☐ Female
Has Individual been previously tested at this facility? ☐ No ☐ Yes, Praxis ID# :_____	Specimen Source ☐ Whole Blood ☐ Cultured Cells, Source _____ ☐ Tissue, Source _____ ☐ Extracted DNA, Source _____ ☐ CVS ☐ Direct Amniotic Fluid **NOTE:** Currently all production testing provided requires Whole blood or Cultured Cells. Praxis Genomics only accepts other sample types for testing for mutually approved research purposes.	LAB USE ONLY Blood Transfusion / Marrow Transplant ☐ No ☐ Within Last 30 Days, Date and Type _____ / _____ / _____ Type: _____ MONTH DAY YEAR	
Relationship to Sample 1, if known			

Sample 4

Last (Family) Name	First Name	MI	Date of Birth _____ / _____ / _____ MONTH DAY YEAR
	Specimen Collection Date / Shipping Condition _____ / _____ / _____ MONTH DAY YEAR ☐ Room Temperature ☐ Frozen		Sex ☐ Male ☐ Female
Has Individual been previously tested at this facility? ☐ No ☐ Yes, Praxis ID# :_____	Specimen Source ☐ Whole Blood ☐ Cultured Cells, Source _____ ☐ Tissue, Source _____ ☐ Extracted DNA, Source _____ ☐ CVS ☐ Direct Amniotic Fluid **NOTE:** Currently all production testing provided requires Whole blood or Cultured Cells. Praxis Genomics only accepts other sample types for testing for mutually approved research purposes.	LAB USE ONLY Blood Transfusion / Marrow Transplant ☐ No ☐ Within Last 30 Days, Date and Type _____ / _____ / _____ Type: _____ MONTH DAY YEAR	
Relationship to Sample 1, if known			