The HudsonAlpha CLINICAL SERVICES LAB

REQUEST FOR REANALYSIS/REINTERPRETATION

1. Request Information

Patient Name: _____ Date of Birth: _____
Last First (MM/DD/YYYY)

Reason for Reanalysis/Reinterpretation: _____

_____

REQUIRED: Please include up-to-date clinical information with this request.

2. Sequencing Laboratory *(laboratory where the data was generated)*

******For data generated outside a CLIA-certified laboratory, a research report will be issued.******

Sequencing Laboratory: _____

Address: _____ City: _____

State: _____ Zip Code: _____ CLIA License Number: _____

3. Data Format

A. Select the file format(s) being provided to HudsonAlpha Clinical Services Lab, LLC (*check all that apply*):

❑ FASTQ ❑ aligned BAM

❑ VCF ❑ Other: _____

B. Select data transfer method:

❑ Encrypted hard drive ❑ Secure file transfer

❑ Encrypted email ❑ Other: _____

4. Limitations *(not applicable if sequencing performed at HudsonAlpha Clinical Services Lab)*

I acknowledge that data generated by an outside sequencing laboratory may not meet the standards for sequencing data generated by the HudsonAlpha Clinical Services Lab, LLC. Subsequent reanalysis/reinterpretation of this data is limited by the quality of the data received. HudsonAlpha Clinical Services Lab, LLC is not responsible for variants not detected due to poor quality data generated by an outside sequencing laboratory.

_____ _____
Patient Signature (or Designee) Date (MM/DD/YYYY)

_____ _____
Ordering Clinician Signature Date (MM/DD/YYYY)

Please submit this form with a completed **Clinical Test Requisition Form**.