ASPARAGINASE SAMPLE SUBMISSION FORM

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North Chesterfield, VA 23235
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PATIENT INFORMATION

_____
Last Name **First Name** **M.I.**

_____
Street Address

_____
City State Zip Code

DOB: _____ SSN: _____

SEX: Male ☐ Female ☐

MRN # / Sample ID: _____

Samples should be shipped cold by overnight express for delivery Monday through Friday. Granger Genetics is closed Saturday and Sunday.

*See sample submission requirements on the back of the page

PHYSICIAN / INSTITUTION INFORMATION

Institution Name: _____

Physician Name: _____

Billing Address: _____

_____

Phone: _____ Fax: _____

_____
Name of Person Completing this Submission Form & Date

SEND DUPLICATE REPORT TO:

_____
Last Name First Name

_____
Fax Number Phone Number

SAMPLE INFORMATION

Date of Collection: _____ Time of Collection: _____

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

If Yes Date of last Injection: _____ Time of last Injection: _____

L-asparaginase administered: (Mark One) ☐ Oncaspar ☐ Erwinaze ☐ Other _____

ASSAY REQUESTED

☐ Asparaginase Activity **OR** ☐ Asparaginase Antibody **OR** ☐ Both (Activity and Antibody)

SAMPLE TUBE LABEL AND COMMENTS

SPECIMEN REQUIREMENTS

Specimen: Serum

Collection: Venous Collection, Red-top tube or gel-barrier tube, separate serum from RBCs within 2 hours, Freeze/Refrigerate serum immediately

Volume: 0.5 – 2 mL

Storage Instructions: Freeze prior to transport. Sample may be refrigerated at 2°C to 8°C, see stability below.

Temperature	Timeframe (activity assay)	Timeframe (antibody assay)
Room Temperature	1 Day	4 Hours
Refrigerated	3 Days	3 Days
Frozen	30 Days	7 Days
Freeze/Thaw Cycles	3 Cycles	3 Cycles