Progene DX

Tube ID #s
On the tube labels — A/B

Ordering Health Care Provider:	
Email:	Phone:
Address:	

Patient Information

Progene DX will use the Tube ID #s (above) to communicate with you about this assay. Be sure to record the Tube ID #s and Order # (above) in your patient's file. When filling the tubes be sure to use only the tubes that came with this order – you can tell by the Tube ID #s on the tubes. **Do not provide the patient's name, address, SSN or any personally identifiable information on any paperwork including additional studies you send us**.

Sex (circle): Male / Female Birth year (yyyy only)_____ Height:_____ Weight:_____

Racial Heritage:_____ Years of education (high school=12; college=16)

Top 10 symptoms

Differential Diagnosis Considered

Biotoxin exposure

If mold, what was HERTSMI-2? _____ What was ERMI? _____Attach copy please

I. was there visible mold? …..……..... Yes No

II. were there musty smells? …..……..... Yes No

III. was actinomycetes testing performed? ..... Yes No Please attach

IV. was endotoxin testing performed? ..... Yes No Results_____

If patient is CIRS-WDB, when was last exposure to WDB prior to GENIE draw:_____

If Lyme, was there any ECM rash? ……..... Yes No

Positive Western Blot? (from Quest, LabCorp or Stony Brook) Yes No

Circle the number indicating the stage of CIRS therapy:

1. Naïve (prior to CSM protocol) 2. After removal from exposure and started CSM protocol

3. Currently on VIP 4. Finished VIP 5. Relapse

Diagnostic studies

IMPORTANT For best results, we request the following tests be conducted at the same time as the GENIE assay; within 1 week is acceptable. In the case that your patient is unable to provide concurrent tests please indicate the date of the test results you are providing.

If you are conducting concurrent tests, please copy this page and retain in your patient's file while waiting for test results. When you have received all the test results, please complete your copy of this page (along with supporting pages i.e. VCS, NeuroQuant, etc.) and mail to CRBAI, 500 Market St., Suite 103, Pocomoke City, MD 21851. Be sure to only identify additional pages using the Tube ID #s above.

TEST **Test Date (mmm/dd/yy)**

HLA DR by PCR _____

MARCoNS: Positive / Negative (circle one and attach report) Date_____

VCS: Positive / Negative (circle one and attach report) Date_____

MSH _____ Date_____

TGF beta-1 _____ Date_____

MMP-9 _____ Date_____

VEGF _____ Date_____

C3a (Quest only) _____ Date_____

C4a (Quest only) _____ Date_____

ADH/osmolality _____ Date_____

ACTH/cortisol _____ Date_____

AGA _____ Date_____

von Willebrand's profile (Quest only)_____ Date_____

Pulmonary stress test (please attach) V02 max _____ Date_____

Stress ECG (please attach) PASP Before_____PASP After _____ Date_____

NeuroQuant (attach copy of General Morphometry Report) Date_____

Prior use of anti-fungals Y / N (circle one). If yes, type and route _____

Pertinent additional studies (please attach).

If you have any further information or need more space please attach as many pages as you need. If you have questions about this form please call us at (410) 957-1550.