

BCR-ABL1 Genetic Test

Applicant Details:

Name: _____

Date of Birth: _____

Address: _____

Contact Number: _____

Email Address: _____

Medical Practitioner/Requesting Physician:

Name: _____

Contact Number: _____

Hospital/Clinic: _____

Sample Information:

1. Sample Type: _____ (e.g., Blood, Bone Marrow)

2. Date of Collection: _____

3. Time of Collection: _____

Test Details:

1. Test Type: _____

2. Method: _____

3. Purpose: _____

Results:

1. BCR-ABL1 Transcript Level (%): _____

2. International Scale (%): _____

3. Log Reduction: _____

4. Control Gene (ABL1, BCR, or GUSB) Quantity: _____

Interpretation:

☐ Positive:

- Major (e13a2 or e14a2) or Minor (e1a2) Transcript Type: _____

- **Comments:**

☐ **Negative:**

Recommendations/Follow-up:

Physician's Signature: _____ **Date:** _____

Laboratory Director's Signature: _____ **Date:** _____

Disclaimer: This test is for clinical purposes. Results should be interpreted in conjunction with other clinical findings and laboratory tests. Please consult your healthcare provider for medical advice.

This template is a basic example and might not include all the details that specific laboratories or healthcare providers might require. The lab that conducts the test would likely have its own detailed form or report format.