## Alpha-1 Antitrypsin Genotype, Serum and Whole Blood

Test ID: A1ATG SB, St. Paul's Hospital Laboratory, 1081 Burrard St, Vancouver, BC V6Z 1Y6

The following information is required when requesting Alpha-1 Antitrypsin Genotype testing.

Please complete and submit with your order. Section A and B is mandatory.

A. Order Information	(ICL use only)
Patient name:	
Date of Birth:	
Collection Date:	
Specimen #:	
B. Mandatory Information	
Serum A1AT Concentration (g/L):	
Testing is only available if one or more of the following is/are applicable.	
Please indicate:	
$\square$ Serum A1AT concentration is <= 1.15 g/L.	
$\Box$ There is a documented family history of A1AT deficiency. (Please complete section D below)	
$\Box$ There is liver disease and A1AT concentration is < 1.50 g/L.	
$\Box$ The patient has COPD that is unusually severe and unexplained.	
C. Clinical Symptom of A1AT deficiency (optional):	
☐ Lung Disease	
☐ Liver Disease	
Additional disease description (e.g., early onset COPD; PASD + liver biopsy; Neonatal cholestasis):	
D. Family history for asymptomatic patient requesting genetic testing for counseling purpose (optional):	