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.