SHODAIR CHILDREN'S HOSPITAL GENETICS LABORATORY
2755 Colonial Dr, Helena. MT, 59601 (406) 444-7532 (800) 447-6614
Fax (406) 444-1022, email: mtgene@shodair.org

SHODAIR LAB #:

DNA LABORATORY TEST REQUEST FORM (*Please send this completed form with the specimen*)

PATIENT LAST NAME: ______________________________ **FIRST NAME** : ________________________________ **DOB**:__________

SEX: M / F **REF. LAB #:** ______________________ **DATE COLLECTED**:________________ **DATE RECEIVED:** _______________

ETHNIC BACKGROUND: (Circle all that apply) European Caucasian, Hispanic, Native American, African American, Asian, Other

REFERRING PHYSICIAN/HEALTH CARE PROFESSIONAL:
Name: ____
Address: ____
City, State, Zip: ____
Telephone:(_____)______________ FAX:(_____)________________

REFERRING INSTITUTION / CLINIC / LABORATORY:
Name: _______________________________________

ADDITIONAL REPORTS TO:
Name: __________________________________

PHYSICIAN SIGNATURE: **Date:**
(Required for Medicare / Medicaid billing)

BILLING INFORMATION:
- ❑ **REFERRING INSTITUTION**

New Clients please call Laboratory with financial contact information.

❑ **INSURANCE**
Name of policy holder:_________________________
Policy holder DOB:___________________________
SS # (Guarantor): _________________________
Address:_____________________________________
Phone #:_____________________________________
Relationship to patient:_________________________
Insurance Co. / Policy #:________________________
Insurance Co Contact / Phone :___________________

❑ **MEDICAID #:**_____________________
State (MT, WY, CO, UT): ________________
SS#:_______________________________

❑ **SELF PAY**

❑ **INPATIENT**

TEST REQUESTED: (Please check one or more; test descriptions with CPT codes and prices faxed on request)

- ❑ **Hemochromatosis (HFE) Mutations (C282Y / H63D)**
- ❑ **Factor V Leiden (FVL) Mutation**
- ❑ **Prothrombin (Factor II) Polymorphism**
- ❑ **Factor V Leiden / Prothrombin / MTHFR Variant**
- ❑ **Huntington Disease (HD) Mutation**
- ❑ **X-Chromosome Inactivation**
- ❑ **Zygosity (Twin) Studies**
- ❑ **Maternal Cell Contamination Analysis**
- ❑ **Microarray**
- ❑ **Other (Specify:______________________________)**
- ❑ **Uniparental Disomy Screen (Chromosome ________)** (chromosomes 2, 6, 7, 8, 9, 11, 13, 14, 15, 16, 20, 21)
  *** Note: Parents required for UPD studies**
- ❑ **Angelman Syndrome (AS) Methylation**
- ❑ **Prader- Willi Syndrome (PWS) Methylation**
- ❑ **Fragile X Syndrome (FMR-1): DNA only**

Beckwith-Wiedemann Syndrome
- ❑ **KCNQ1OT1 & H19 Methylation**
- ❑ **UPD 11**

Russell-Silver Syndrome
- ❑ **H19 Methylation**
- ❑ **UPD 7**

CLINICAL INFORMATION / INDICATION FOR TEST:

Reason for Testing:
- ❑ **Diagnostic**
- ❑ **Family History**
- ❑ **Carrier Testing**
- ❑ **Prenatal**

ICD-9 Code:

Clinical Findings / History :

Pregnancy history (gravida/para/ab):

Gestational age & method (US, LMP):

ADDITIONAL FAMILY MEMBERS TO BE STUDIED AND RELATIONSHIP (provide parents names & dates of birth for UPD studies)

1. ____

2. ____

SPECIMEN TYPE: (Please check) PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT.

- ❑ **Cultured amniocytes** (Two confluent T25 flasks, please retain a backup)
- ❑ **Cultured chorionic villus (CVS) cells** (Two confluent T25 flasks, please retain a backup)
- ❑ **Direct amniotic fluid or CVS** (Please call the laboratory to arrange)
- ❑ **Blood:** EDTA (purple top tube) or ACD (yellow) 5 to 10 ml, minimum 1 ml for infants, room temp

For chromosome analysis, also submit 3 to 5 ml sodium heparin (green top)

- ❑ **Tissue, Fixed or Fresh, source:** (block or thick sections, please contact lab)
- ❑ **OTHER:**

Please submit 3-5 ml maternal blood collected in an EDTA tube for maternal cell contamination study. We strongly recommend this test when chorionic villus samples results indicate a female fetus (we discard the sample if the results are male). If you do not choose to submit this sample, please check the box below which assures that you have discussed this testing with the patient and she declines this additional testing.

❑ **DECLINE**

Med Rec #	Admit #	Shire #