

SHODAIR LAB #:

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

PATIENT LAST NAME: _____ FIRST NAME : _____ SOC. SEC. #: _____
 DOB: ___/___/___ SEX: M / F / Unk REF. LAB #: _____ DATE COLLECTED: ___/___/___ DATE RECEIVED: ___/___/___
 Resp. Party (Relation to Pt): _____ Address: _____ Phone: (____) _____
ETHNIC BACKGROUND: (Circle all that apply) European Caucasian, Hispanic, Native American, African American, Asian, Other

<p>REFERRING PHYSICIAN/ HEALTH PROFESSIONAL: Name: _____ Address: _____ City, State, Zip: _____ Telephone:(____) _____ FAX:(____) _____</p> <p>REFERRING INSTITUTION / CLINIC / LABORATORY: Name: _____ Address: _____ City, State, Zip: _____ Telephone:(____) _____ FAX:(____) _____</p> <p>ADDITIONAL REPORTS TO: Name: _____ Address: _____ City, State, Zip: _____ Telephone: (____) _____ FAX: (____) _____</p>	<p>BILLING INFORMATION: (Check)</p> <p><input type="checkbox"/> REFERRING INSTITUTION / CLINIC / OFFICE Institution Name: _____ Inpatient: Yes No Billing Address: _____ Financial Contact: _____ Telephone: (____) _____</p> <p><input type="checkbox"/> INSURANCE Commercial: Provide front / back copy of card Managed Care (HMO): Copy of card with authorization Medicaid (MT, WY, CO, UT, ID): Copy of card Name of Policy Holder: _____ Insurance Co / Policy #: _____ Insurance Co Contact / Phone #: _____ SS # (Guarantor): _____ Medicaid # / State: _____</p> <p><input type="checkbox"/> SELF PAY (Please call the laboratory to arrange)</p>
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TEST REQUESTED: (Please check one or more; test descriptions with CPT codes and prices faxed on request)

<p><input type="checkbox"/> Hemochromatosis (HFE) Mutations (C282Y / H63D) <input type="checkbox"/> Factor V Leiden (FVL) Mutation <input type="checkbox"/> Prothrombin (Factor II) Polymorphism <input type="checkbox"/> Factor V Leiden and Prothrombin Multiplex <input type="checkbox"/> Factor V Leiden / Prothrombin / MTHFR Variant <input type="checkbox"/> Fragile X Syndrome (FMR-1): DNA only <input type="checkbox"/> Fragile X Screen: DNA + chromosome analysis <input type="checkbox"/> Myotonic Dystrophy (DM) Mutation <input type="checkbox"/> Prader- Willi Syndrome (PWS) Methylation <input type="checkbox"/> Angelman Syndrome (AS) Methylation <input type="checkbox"/> Huntington Disease (HD) Mutation</p>	<p><input type="checkbox"/> Multiplex Trisomy / Sex Chromosome Screen <input type="checkbox"/> X-Chromosome Inactivation <input type="checkbox"/> Y-Chromosome Detection <input type="checkbox"/> Maternal Cell Contamination Analysis <input type="checkbox"/> Uniparental Disomy Screen (Chromosome _____) * <input type="checkbox"/> Uniparental Disomy 7 (Silver-Russell Syndrome)* <input type="checkbox"/> Uniparental Disomy 15 (Prader-Willi / Angelman) * <input type="checkbox"/> Uniparental Disomy 11 (Beckwith-Wiedemann) * <input type="checkbox"/> LIT1 / KCNQ10T1 Methylation (Beckwith-Wiedemann) <input type="checkbox"/> Zygosity (Twin) Studies <input type="checkbox"/> Other (Specify: _____) * Note: Parents required for UPD studies</p>
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CLINICAL INFORMATION / INDICATION FOR TEST:

<p><input type="checkbox"/> Possible / Probable diagnosis: list symptoms _____ _____</p> <p><input type="checkbox"/> Asymptomatic with family history (detail / draw pedigree to the right or on separate sheet)</p> <p><input type="checkbox"/> Asymptomatic population screen/ Carrier screen</p> <p><input type="checkbox"/> Prenatal <input type="checkbox"/> Previous child <input type="checkbox"/> Pregnancy at risk <input type="checkbox"/> Family history</p>	<p>PREVIOUS DNA OR CHROMOSOME STUDIES? YES NO (if YES, specify results) _____ Individual(s) studied: _____</p> <p>ADDITIONAL FAMILY MEMBERS TO BE STUDIED AND RELATIONSHIP (Provide parents names and dates of birth for UPD studies)</p> <p>1. _____ 2. _____</p> <p style="text-align: right;">(PEDIGREE)</p>
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SPECIMEN TYPE: (Please check) PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT.

<p><input type="checkbox"/> Blood: EDTA (purple top tube) or ACD (yellow) 5 to 10 ml, minimum 1 ml for infants, room temp FOR CHROMOSOME ANALYSIS AS WELL AS DNA, ALSO SUBMIT 3 TO 5 ML HEPARIN (GREEN TOP)</p> <p><input type="checkbox"/> Fixed tissue (block or thick sections, please contact lab)</p> <p><input type="checkbox"/> Fresh tissue, source _____</p> <p><input type="checkbox"/> Other _____</p>	<p>FOR PRENATAL SPECIMENS ONLY Pregnancy history (gravida / para / ab): _____ Gestational age and method (US, LMP): _____</p> <p><input type="checkbox"/> Cultured amniocytes (Two confluent T25 flasks, fill flasks with media, please retain a backup)</p> <p><input type="checkbox"/> Cultured chorionic villous (CVS) cells (Two confluent T25 flasks, fill flasks with media, please retain a backup)</p> <p><input type="checkbox"/> Direct amniotic fluid or CVS (Please call the laboratory to arrange)</p>
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