Children's Hospital Colorado

Children's Hospital Colorado
Department of Pathology & Laboratory Medicine
Precision Diagnostics Lab - Inherited Genetic Disease Requisition
Phone (720) 777-6711
Fax (720) 777-7118

Specimen Shipping Address:
Children's Hospital Colorado
Clinical Laboratory - Room B0200
13123 E. 16th Ave
Aurora, CO 80045

FAILURE TO COMPLETE BELOW FIELDS WILL DELAY RESULTS

****PLEASE PROVIDE COMPLETE BILLING INFORMATION****

Ordering Institution Name:	Ordering Institution Address: Street:_____ City, State, Zip:_____
Ordering Provider (Last, First, and Middle Initial):	Ordering Provider Phone:

Result Contact Name:	Result Phone:	Result Fax:
Client Specimen Label	**Internal Specimen Label**	

Patient Information

Last Name	First Name	Middle Initial	Birthdate (MM/DD/YYYY)	Sex
Client Medical Record Number	Client Specimen Number		Diagnosis/ICD-10 Code	

Specimen Information

Date Collected (MM/DD/YYYY)_____

Time Collected (HHMM)_____AM/PM

□ Fetal Sample[1] (Specify Source Below) Gestational Age_____

□ Cord Blood □ CVS Direct □ Amniotic Fluid Direct

□ CVS Tissue Culture □ Amniotic Fluid Tissue Culture

□ Blood □ Tissue-FFPE Source:_____

□ Bone Marrow □ Tissue-Frozen Source:_____

□ Nail Clippings □ Tissue-RPMI Bone Marrow Core, Source: Bone Marrow Biopsy Source:

□ Extracted DNA[2] □ Tissue-RPMI Source:

□ Extracted RNA[2] □ Buccal Swab

□ Other:

Additional Information

FAILURE TO COMPLETE BELOW FIELDS WILL DELAY RESULTS

Bill To: □ Submitter/Client

Billing Contact Information:	**□ Billing Facility and Address same as Submitter Listed**
Name:	Insitution Name:
Email:	Address (incl. City, State, Zip):
Phone:	Phone: Fax:

Bill To: □ Patient Insurance

******If below items are not included WITH the specimen, the referring provider will be billed directly and responsbile for payment******
A face and or demographic sheet with the following criteria MUST be provided:

- Patients Full Name
- Patients Full Address (City, State
- Patients Phone Number
- Patients Insurance Name and Plan Type (Primary and Secondary)
- Policy/ID Number
- If Subscriber is different than patient - a DOB is REQUIRED

[1] If submitting fetal/prenatal specimen, a maternal specimen for MCC testing is also required. Please complete maternal sample section on the back of this page. [2] I attest that the extracted nucleic acid has been isolated in a CLIA-certified laboratory or a laboratory deemed equivalent by CAP/CMS.

Children's Hospital Colorado

Children's Hospital Colorado
Department of Pathology & Laboratory Medicine
Precision Diagnostics Lab - Inherited Genetic Disease Requisition
Phone (720) 777-6711
Fax (720) 777-7118

Specimen Shipping Address:
Children's Hospital Colorado
Clinical Laboratory - Room B0200
13123 E. 16th Ave
Aurora, CO 80045

Client

Next Generation Sequencing (SNV, indels, and copy number variants)

Methylmalonic Acidemia and Homocystinuria Panel		□ **LAB8614**	**Noonan Spectrum Disorders/RASopathies Panel**		□ **LAB8613**
33 gene panel	*AHCY, ABCD4, ACSF3, ALDH6A1, AMN, CBS, CD320, CUBN, GIF, GNMT, HCFC1, IVD, LMBRD1, MAT1A, MCEE, MMAA, MMAB, MMACHC, MMADHC, MTHFD1, MTHFR, MTR, MTRR, MUT, SLC46A1, SUCLA2, SUCLG1, TCN1, TCN2, MLYCD, PRDX1, THAP11, ZNF143*		32 gene panel	*A2ML1, ACTB, ACTG1, BRAF, CBL, CDC42, EPHB4, HRAS, KAT6B, KRAS, LZTR1, MAP2K1, MAP2K2, MAP3K8, MRAS, NF1, NRAS, NSUN2, PPP1CB, PTPN11, RAF1, RASA1, RASA2, RIT1, RRAS, SASH1, SHOC2, SMARCB1, SOS1, SOS2, SPRED1, STAMBP*	
Nonketotic Hyperglycinemia Panel		□ **LAB9148**	**Single Gene Sequence Analysis (SNV, indels, and copy number variants)[3]**		□ **LAB7981** Indicate Gene:
13 gene panel	*AMT, BOLA3, GCSH, GLDC, GLRX5, IBA57, MECR, LIAS, LIPT1, LIPT2, NFU1, SLC25A26, SLC6A9*		**Custom Panel (2 - 50 Genes)** Indicate genes in 'Additional Information' Section		□ **LAB9094**
CHILD Panel[4]	□ include Fragile X FMR-1 Analysis	□ **LAB9571**	**Exome Analysis[4]**		□ **LAB8650**
□ Proband Only □ Familial Analysis - Must Complete Familial Testing Section			□ Proband Only □ Familial Analysis - Must Complete Familial Testing Section		

Panel Reflex to Exome Analysis

Original Specimen ID: _____

Original Panel: _____

□Use all family members from original panel

□Update family members to be tested (Must Complete Familial Testing Section)

□ **LAB9096**

Maternal Sample for Maternal Cell Contamination - REQUIRED FOR ANY PRENATAL TESTING

Date Collected (MM/DD/YY) _____

Time Collected (HHMM) _____ AM / PM

Specimen Source: □ Blood □ Swab □ Other:

□ **LAB7663**

Familial Testing Information (Up to 4 additional samples)

Reason for Testing: □ Diagnostic □ Carrier Testing □ Prenatal (Maternal Cell Contamination Testing Required)

Clinical Indication for Testing:

Relationship to Proband:	□ Proband Only Analysis	□ Mother	□ Father	□ Sibling	□ Other(specify):
Sex:					
Legal Name:					
Date of Birth:					
Clinically Affected:		□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown
Report ACMG secondary findings regardless of primary reason for testing?	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No

Fragment Analysis or Sanger Sequencing

Fragile X FMR1 CGG Repeats (includes Southern blot if positive)	□ **LAB6943**
Factor V Leiden (G1691A) and Prothrombin (20210A) Mutations	□ **LAB8455**
Targeted Known Familial Analysis vis Sanger Sequencing (Up to 5 targets) [3] [4]	□ **LAB8635**

Known Variant 1 *Additional target information should be written in the section below.*	Gene:	Chromosomal Position: (Ex. chr7: 117509047)	Family ID (if known ex: FIN123):
	Transcript ID: (Ex: NM_123456.1)	c.DNA Change: (Ex. c.178Gly>Ala or c.178G>A)	Protein Change: (Ex. p.Glu60Lys or p.E60K)

Additional Information

Pedigree, Clinical Information or Special Instructions (attach pedigree):

Signature of Consent Required for All Laboratory Testing:
I certify that the patient specified above and/or their legal guardian has been informed of the benefits risks and limitations of the laboratory test(s) requested. I have answered all questions and have obtained informed consent from the patient or their legal guardian for this testing.

Name: **Signature:** **Date:**

[3] Charges applicable per gene. [4] Gene list available upon request.