THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Biochemical Genetics Laboratory Department of Pediatrics
Biochemical Test Requisition

Patient Sticker Here

Basic Sciences & Education Bldg
941 Stanton L. Young Blvd, Rm 229
Oklahoma City, OK 73104
Phone: 405-271-8685
Fax: 405-271-7117
After hours phone: 405-239-0382
E-mail: andrea-wierenga@ouhsc.edu
Website: oumedicine.com/geneticslab

REFERRING PHYSICIAN/FACILITY

Requesting Physician _____

Physician's Phone (____)_____ Cell/Pager (___)_____

Clinic/Hospital _____

Phone (___)_____ **Fax results to** (____)_____

Preliminary and final reports will be faxed to the number listed on the requisition form. Failure to list a fax number will delay receipt of patient results.

Genetic Counselor _____ Phone (____)_____

Cell/Pager (____)_____ Fax (___)_____

PATIENT AND BILLING INFORMATION

Patient Name (last,first,middle) _____

DOB _____ SSN _____ MRN _____

Gender: □ Male □ Female □ Inpatient □ Outpatient

Patient's Address _____

City _____ State _____ Zip Code _____

Insurance Co. _____ Auth/Referral # _____
(Provide a copy front and back of insurance card)

I consent to have the following test(s) performed. I authorize my insurance company to pay these providers for services filed on my behalf. I authorize release of information necessary to secure payment from my insurance. I understand that I am responsible for all charges incurred, and I agree to pay for services as they are provided and pay promptly upon receipt of a statement. (Outpatients only sign here to consent.)

_____
Patient/Guardian Signature Date

SPECIMEN/CLINICAL INFORMATION

Primary presenting symptoms:

_____

You may also list ICD-9 codes

Suspected Diagnosis:

_____

Medications: _____

Diet or Infant Formula: _____ Date Specimen Collected _____ Time _____

SPECIMEN TYPES & COLLECTION REQUIREMENTS

□ **Plasma**
1-2 mL (from whole blood collected in sodium heparin tube [dark green top]). Keep specimen cold. Freeze for shipment or off-hours.

□ **Serum**
1-2 mL (from whole blood collected in a red-top tube). Keep specimen cold. Freeze for shipment or off-hours.

□ **CSF**
1 mL collected in a sterile container. Keep specimen cold. Freeze for shipment or off-hours.

□ **Urine**
2-5 mL collected in a sterile container with no preservatives. Freeze for shipment or off-hours.

□ **Dried blood spot card (DBS)**
3 to 5 completely filled spots

TEST INFORMATION

Test Type

□ **Quantitative Amino Acids**

ADDITIONAL REPORT

Physician/Facility _____

Phone (___)_____ Fax (___)_____

Address _____

_____

☐ OU Medical Center Clinical Laboratory Referral

BIOCHEM LABORATORY USE ONLY

Laboratory Number _____

Date & Time of Pick-Up/Delivery _____

Initials _____ Check-in _____

Entered in Database _____ Additional Specimen(s) sent for this patient _____

Previous Lab Number _____