THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Genetics Laboratory Department of Pediatrics
Molecular Genetics Requisition

Basic Sciences & Education Bldg
941 Stanton L. Young Blvd. 224
Oklahoma City, OK 73104
Phone: 405-271-3589
Fax: 405-271-7117
After hours phone: 405-496-9514
www.genetics.ouhsc.edu

Patient Sticker Here

Please have all specimens delivered to the Core lab of OU Medical Center in Everett Tower basement

REFERRING PHYSICIAN/FACILITY

Requesting Physician_____

Physician's Phone_(____)_____Cell/Pager_(___)_____

Clinic/Hospital DLO at Integris Baptist Medical Center

Phone_(405) 949-6829_____Fax_(405)945-5445

Preliminary and final reports faxed to the referring physician or facility please provide appropriate fax number(____)_____

Genetic Counselor_____Phone_(____)_____

Cell/Pager_(____)_____

PATIENT AND BILLING INFORMATION

Patient Name (last,first,m.)_____

DOB_____ SSN_____ MRN_____

Sex: Male Female Ambiguous ☐ Inpatient ☐ Outpatient

Patient's Address_____

State_____ Zip Code_____ Phone Number_(____)_____

'STAT' specimen to pass through DLO

SPECIMEN/CLINICAL INFORMATION

Reason for study (clinical indications or ICD-9 codes) _____

_____ Date Collected_____ Time_____ Initials_____

SPECIMEN REQUIREMENTS

☐ **Peripheral Blood**
3-5 cc in a large EDTA tube (purple top),mix well. Specimen must be kept at room temperature or cooler, do not freeze.

☐ **Amniotic Fluid**
5-10 cc in sterile centrifuge tubes. required. Keep specimen cool but do not freeze. **Gestational age by:** ultrasound_____ or LMP_____ Gravida__ __ Para__ __ __ __

☐ **Buccal Swab**
Collect 3 DNA specimens with nylon brushes. Rub the tip of the brush firmly along the inside of the cheek, place the cap on the brush. Keep at room temperature. This specimen type cannot be used for Fragile X studies.

☐ **Other** (please specify)_____
Contact laboratory before sending specimen.

TEST INFORMATION

Please Select One of the Following Studies:

☐ Cystic Fibrosis
☐ Fragile X study
☐ MCAD (Medium-Chain-Acyl-CoA-Dehydrogenase deficiency)
☐ Prader-Willi syndrome Methylation
☐ Angelman syndrome Methylation
☐ Uniparental disomy (UPD) chromosome_____
☐ Sickle Cell disease
☐ Y chromosome deletion
☐ Micro-Array
☐ Huntington Disease (PCR/Southern blot)

ADDITIONAL REPORT

Physician/Facility_____

Phone_(___)_____ Fax_(___)_____

Address_____

_____

☐ OU Medical Center Clinical Laboratory Referral

GENETICS LABORATORY USE ONLY

Laboratory Number_____

Date & Time of Pick-Up/Delivery_____

Location_____

Initials_____ Check-in_____ Checked Database_____

Entered in Database_____ Additional Specimen(s)sent for patient_____

Previous Lab Number_____