THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Genetics Laboratory Department of Pediatrics
Sequencing Requisition

Patient Sticker Here

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

'STAT' specimen to pass through DLO

REFERRING PHYSICIAN/FACILITY

Requesting Physicians_____

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

Clinic/Hospital_____

Phone_(___)__949-6829_____ **Fax results to**_(____)_945-5445_____

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,m.)_____

DOB_____ SSN_____ MRN_____

Sex: Male Female Ambiguous □ 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

Diagnosis/Clinical Findings/Family History _____

You may also list ICD-9 codes

Date Specimen Collected_____ Time_____

SPECIMEN TYPES & COLLECTION REQUIREMENTS

□ Peripheral Blood

3-5 cc in large EDTA tube (purple top), mix well. Keep specimen at room temperature or cooler, do not freeze. For NF1 testing an additional 3cc of blood is required and should be collected in a sodium heparin tube (dark green top). This will be used for FISH testing if no mutation is found through sequencing.

□ Amniotic Fluid □ CVS □ Cultured amniocytes

Sequencing will only be performed on amniotic fluid specimens if one or both parents have laboratory confirmed diagnoses of NF1. Please provide a copy of that lab report.

DO NOT TRANSPORT SPECIMENS IN SYRINGES!
Collect 15-20 cc and transfer to sterile centrifuge tubes. Keep specimen cool but do not freeze. For cultured amniocytes please send two T-25 flasks.
Gestational age by: ultrasound_____ or LMP_____

□ Buccal swab (MCAD/SCAD sequencing only) Collect 3 specimens

w/nylon brushes by rubbing the brush firmly along the inside of the cheek for 10-15 seconds. Place the cap on the brush, making sure it is tightly sealed. Keep fresh sample at room temperature.

□ Isolated DNA please contact lab before sending

TEST INFORMATION

□ Neurofibromatosis 1 (complete NF1 patient consent form)

□ SPRED 1 □ Wilsons disease ATP7B

□ MCAD □ SCAD □ VLCAD

□ ATP6V0A4 □ Bernard-Soulier syndrome GP1Bb

□ Marfan syndrome FBN1 □ Cockayne syndrome type A ERCC8

□ Bartter syndrome type 2 KCNJ1 □ PTEN

□ Marinesco-Sjorgen syndrome (MSS) SIL1

□ Connexin 26 *GJB2* □ Connexin 30 *GJB6*

□ Cystic Fibrosis CFTR □ Sotos syndrome NSD1

□ Niemann-Pick disease type C □ Rett syndrome MECP2

Noonan syndrome: □ PTPN11 □ SOS1 □ KRAS □ RAF1

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_____

Entered in Database_____ Additional Specimen(s) sent for this patient_____

Previous Lab Number_____