UCLA Health System

DNA REPAIR CLINICAL TESTING LABORATORY REQUISITION FORM 1

10833 Le Conte Ave, Room 1P-201 CHS,
Los Angeles, CA 90095-1732
Phone:(310)825-7200 Fax: (310)825-7618
http://www.odtc.ucla.edu

FOR PATHOLOGY USE ONLY

PATIENT NAME: (LAST) (FIRST)

MEDICAL RECORD NUMBER:

DATE OF BIRTH: SEX: M F

ATTACH DEMOGRAPHIC LABEL OR FILL IN ALL ABOVE INFORMATION

IF NOT A UCLA PATIENT: PLEASE PROVIDE PAYOR/INSURANCE INFORMATION

_____
ORDERING PHYSICIAN NAME (LAST, FIRST) (PRINT CLEARLY)

_____ _____ _____
ORDERING PHYSICIAN SIGNATURE DATE TIME

ADDRESS:_____

_____

PHONE:_____ FAX:_____

COPY TO: _____ ID#_____

_____ ID#_____

ADDRESS:_____

PHONE:_____ FAX:_____

UCLA PHYSICIAN ID NUMBER

M	M	D	D	Y	Y

COLLECTION DATE

SPECIMEN DRAW TIME:_____

SPECIMEN COLLECTED BY:_____

SPECIMEN TYPE

Please Ship at Room Temperature

☐ One 7ml green-top (sodium heparin), whole blood

☐ Fibroblast Culture

☐ DNA Only

PATIENT INFORMATION/HISTORY

Pertinent Family History:_____

Ethnicity:_____

☐ Consanguinity: ☐ Yes ☐ No
☐ Familial Mutation(s) Known:_____

Primary Counseling Issue for Genetic Disease
☐ Proband Diagnosis:_____
☐ Prenatal Diagnosis:_____
☐ Carrier Screen:_____
☐ Presymptomatic Diagnosis:_____
☐ Other:_____

GENETIC

☐ 9041 Prenatal diagnosis for A -T (call to schedule: 310-825-7201)

NUCLEAR FOCI (IRIF)

☐ H2AX (post-IR)
☐ 53BP1 (post-IR)
☐ p53 (post-IR)
☐ pBRCA1 (post-IR)
☐ ATM (post-IR)
☐ Rad51 (post-IR)

FUNCTIONAL FLOW

☐ pSMC1 (A-T hom/het/normal)
(Call to Schedule: 310-825-7201)
☐ pH2AX
☐ p53
☐ BRCA 1

IMMUNOBLOT

☐ Immunoblot/colony survival package (9040a)
☐ ATM protein (9040)
☐ NBS/NBN protein
☐ Mre 11 protein
☐ Rad 50 protein
☐ Aprataxin protein (AOA1)
☐ Senataxin protein (AOA2)
☐ DNA-PK kinase protein
☐ Artemis protein
☐ Ku80/90 protein
☐ Fanconi pathway proteins ($FANCD_2$ monoUb)
☐ RNF 168 protein

RADIOSENSITIVITY

☐ colony survival assay -lymphoblasts
☐ colony survival assay -fibroblast
☐ pSMC1 kinetics - 4 timepoints
☐ pH2AX kinetics – 4 timepoints

MISCELLANEOUS

☐ ATM protein by ELISA

☐ Other:_____
_____
_____

DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE
DNA Repair Clinical Testing Laboratory
Richard Gatti, M.D.,Director
Wayne W. Grody, M.D., Ph.D., Co-Director
Phone: (310) 825-7200

UCLA Health System

DNA REPAIR CLINICAL TESTING LABORATORY
REQUISITION FORM 2

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Los Angeles, CA 90095-1732
Phone:(310)825-7200 Fax: (310)825-7618
http://www.odtc.ucla.edu

FOR PATHOLOGY USE ONLY

PATIENT NAME: (LAST) (FIRST)

MEDICAL RECORD NUMBER:

DATE OF BIRTH: SEX: M F

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Instructions for Referred Testing

Specimen: Follow specimen instructions on the requisition form.
Label all specimens with Patient name, I.D. numbers, date and time of collection.
To arrange for the "FC-SMC1" assay, please call (310) 825-7200 before drawing blood samples

Information: Fill out Client information, Patient information, and Specimen information areas. Submit a separate form for each patient (copies are acceptable). Select test being requested.

Mail:
Please ship **OVERNIGHT EXPRESS AT ROOM TEMPERATURE.**
Send specimens with completed forms (**Monday** through **Thursday)** to:

Pathology Outreach Services
Room 1P-201 CHS (Mail Code 173216)
10833 Le Conte Avenue
Los Angeles, CA 90095-1732

For technical questions, please call (310) 825-7200, UCLA Molecular Pathology Laboratory
For billing questions, please call (800) 718 9505, GGB billing

Referring Laboratory / Physician Information

Name: _____ **Phone:** _____ **FAX :** _____

Address: _____
City State Zip

Requesting Physician: _____
UPIN: _____ **Phone:** _____ **FAX:** _____

Billing Information

We will bill Referring Institution, Laboratory or Physician.
If patient will be paying the bill, payment must accompany test request and should be made payable to:

Regents of University of California.
For additional billing information please call the Department of Pathology billing service **GGB** at: **(800) 718-9505**.