SaintFrancis Health System Center for Genetic Testing at Saint Francis
Saint Francis Laboratory • 6161 South Yale Avenue • Tulsa, OK 74136
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CAP # 2050201

MOLECULAR GENETICS LABORATORY TEST REQUISITION

411-001H front / 11-09

PATIENT / SPECIMEN INFORMATION

PATIENT NAME - *LAST, FIRST, MI* ☐ M ☐ F	SSN OR MRN	DATE OF BIRTH

RACE	DIAGNOSIS - *INDICATIONS FOR TESTING*

ICD9	SPECIMEN TYPE	COLLECTION DATE	TIME	CONSENT OBTAINED
				☐ Yes ☐ No

REFERRAL SOURCE

REQUESTING / CONTACT PHYSICIAN	PHONE NUMBER	**FAX** NUMBER

PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE	FAX RESULTS
	☐ Yes ☐ No

REFERRING FACILITY	PHONE NUMBER	**FAX** NUMBER

FACILITY ADDRESS, CITY, STATE, ZIP - *IF DIFFERENT FROM ABOVE*	FAX RESULTS
	☐ Yes ☐ No

ADDITIONAL REPORTS TO

MOLECULAR GENETICS TESTS

☐ Achondroplasia (FGFR3)	☐ Hearing Loss - Mitochondrial Mutation A1555G	☐ Pfeiffer Syndrome (only FGFR1 - P252R)
☐ Alagille Syndrome (JAG1) - RNA[5]	☐ Hearing Loss - Mitochondrial Panel (mtA1555G & MTTS-1)	☐ Pick Disease (FTDP) - exon 10 only
☐ Alagille Syndrome (JAG1) - DNA[5]	☐ Hearing Loss - MTTS1	☐ Pick Disease (MAPT Complete gene)
☐ Albright Hereditary Osteodystrophy (GNAS1)	☐ Hearing Loss - Pendred Syndrome (SLC26A4)	☐ Polycystic Kidney Disease (PKD1 Linkage)[2]
☐ ALS (Lou Gehrig's Disease; SOD1)	☐ Hearing Loss - Waardenberg, type 1 & 3 (PAX3)	☐ Polycystic Kidney Disease (PKD2 Linkage)[2]
☐ Androgen Insensitivity Syndrome	☐ Hearing Loss - Waardenberg, type 2 (MITF)	☐ Prader-Willi Syndrome (Methylation)
☐ Angelman Syndrome (Methylation)	☐ Hearing Loss - Waardenburg Syndrome panel (PAX3 & MITF)	☐ Prader-Willi Syndrome (UPD)[5]
☐ Angelman Syndrome (UPD)[5]	☐ Hemochromatosis	☐ Prothrombin
☐ Apert's Syndrome (FGFR2)	☐ Huntington Disease (HD)[4]	☐ Pseudohypoparathyroidism (GNAS1)
☐ Beckwith-Weidemann Syndrome (UPD)[5]	☐ Hypochondroplasia (FGFR3)	☐ Saethre-Chotzen Syndrome (TWIST)
☐ Blau Syndrome (NOD2/CARD15 Complete Gene)	☐ Hypotonia Panel (DM, PWS, SMA)[3]	☐ SOD1 (ALS, Lou Gehrig's Disease)
☐ Congenital Adrenal Hyperplasia[6] (21-hydroxylase deficiency)	☐ JAK2 (V617F)	☐ Spinal & Bulbar Muscular Atrophy (SBMA; Kennedy Disease)
☐ Connexin 26 gene	☐ K-ras[5] (codons 12 and 13)	☐ Spinal Muscular Atrophy, Types 1, 2, & 3 (SMA)
☐ Connexin 30 gene	☐ Li-Fraumeni Syndrome (p53)[5]	☐ Spinocerebellar Ataxia, Type 2 (SCA2)
☐ Craniodysmorphology Screen (FGFR 1, 2, & 3)	☐ Marfan Syndrome - unknown mutation - RNA[5] (FBN1)	☐ Spinocerebellar Ataxia, Type 3 (SCA3; MJD)
☐ Craniodysmorphology Panel (FGFR TWIST)[3]	☐ Marfan Syndrome - unknown mutation - DNA (FBN1)	☐ Spinocerebellar Ataxia, Type 6 (SCA6)
☐ Crohn's Disease (NOD2/CARD15 Complete Gene)	☐ Marfan Syndrome - known mutation (FBN1)	☐ Spinocerebellar Ataxia, Type 7 (SCA7)
☐ Crohn's Disease (NOD2 susceptibility markers)	☐ Marfan Syndrome Neonatal exons (FBN1)	☐ Spinocerebellar Ataxia Panel (SCA1, 2, 3, 6, & 7)[3]
☐ Crouzon Syndrome with Acanthosis Nigricans	☐ Marfan Syndrome - Linkage[2] (FBN1)	☐ Thyroid Hormone Receptor β
☐ Cystic Fibrosis	☐ Marfan Syndrome, Type 2 - TGFBR1 gene	☐ Uniparental Disomy[5] *(Locus)* _____
☐ DRPLA	☐ Marfan Syndrome, Type 2 - TGFBR2 gene	☐ Waardenberg Syndrome Panel (PAX3 & MITF)
☐ Dwarfism Panel[3] (Achondroplasia & Hypochondroplasia)	☐ Marfan Syndrome, Type 2 Panel (TGFBR1 and TGFBR2)	☐ Waardenberg Syndrome, type 1 & 3 (PAX3)
☐ Dystonia (DYT1)	☐ Maternal Cell Contamination[7]	☐ Waardenberg Syndrome, type 2 (MITF)
☐ EGFR Mutation Analysis[5]	☐ MCAD	☐ Warfarin Sensitivity Genotyping (CYP2CD and VKORC1)
☐ Factor V Leiden	☐ McCune - Albright Syndrome[5]	☐ X-inactivation
☐ Familial Adenomatous Polyposis (Linkage)[2]	☐ MELAS (mt A3243G)	☐ Other:
☐ FGFR (FGFR1, 2, & 3)	☐ MERRF (mt A8344G)	**OTHER SERVICES**
☐ FGFR2 Gene (Reflex from Craniodysmorphology Tests)	☐ Mitochondrial Panel (MELAS, MERRF, & NARP)[3]	☐ Linkage - known allele (include report)
☐ FGFR (FGFR1, 2, 3, & TWIST)[3]	☐ Mitochondrial Hearing Loss - mt A1555G	☐ Nucleic Acid Extraction
☐ Fragile X Syndrome	☐ Mitochondrial Hearing Loss - MTTS1	☐ Sequencing - known mutation (include report)
☐ Friedreich's Ataxia (FRDA)	☐ MTHFR	☐ Tier Testing
☐ FTDP (Pick Disease; Tauopathy; MAPT) - exon 10 only	☐ Muenke Syndrome (only FGFR3 - P250R)	
☐ FTDP (MAPT Complete gene)	☐ Myotonic Dystrophy	
☐ Frontotemporal Dementia (FTD) panel (GRN and MAPT)	☐ NARP & Leigh Syndrome (mt T8993G)	
☐ GNAS1 gene (AHO, PHP1a)	☐ Neurological Panel (HD, SCA, FRDA, DRPLA)[3]	
☐ GRN gene (PGRN, Granulin)	☐ NOD2/CARD15 gene (Crohn's Disease) (4 Markers)	
☐ Hearing Loss (Connexin26)	☐ NOD2/CARD15 Complete Gene Analysis	
☐ Hearing Loss (Connexin30)	☐ Nonsyndromic Craniodysmorphoiogy (Muenke Syndrome)	
☐ Hearing Loss - CX Panel (CX26 & CX30)[3]	☐ P53 (Li Fraumeni Syndrome)	
☐ Hearing Loss - Full Panel (Cx26&30, mt1555)[3]	☐ Pendred Syndrome (SLC264A4)	

2 Cannot be performed on a specimen from a single patient. Family Study, Pedigree REQUIRED
3 Discounted Panel of Tests
4 Consent form MUST accompany specimen (Pre-Symptomatic Patient)
5 Special Instructions : Please Call Laboratory
6 Testing of Parents is STRONGLY recommended when testing prenatal samples
7 REQUIRED for all prenatal testing

CENTER FOR GENETIC TESTING AT SAINT FRANCIS USE ONLY

DATE RECEIVED	TIME	TYPE / AMOUNT RECEIVED	ACCESSION NUMBER

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BILLING INFORMATION

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PAYMENT INFORMATION - *INDICATE ONE*

☐ **SELF PAY (Payment in Full from Patient or Guarantor)**

☐ Check or Money Order

OTHER

☐ Credit Card ☐ VISA ☐ MC ☐

CARDHOLDER NAME - *PRINT*

ZIP CODE

ACCOUNT NUMBER | EXPIRATION DATE | SECURITY NO.

CARDHOLDER - *SIGNATURE*

Payment for Medical Care: It is understood and agreed that the undersigned or a designated agent will be responsible and assume an obligation to pay the Center for Genetic Testing at Saint Francis all costs for genetic evaluation and testing rendered to the person whose name appears within thirty (30) days after having been notified of the amount due and owing or will work out a satisfactory payment plan with the Center for Genetic Testing at Saint Francis. It is further understood and agreed that the undersigned or designated agent will, at all times, remain responsible for the costs of said genetic evaluation and testing.

PATIENT SIGNATURE - *MUST BE 18 YEARS OR OLDER TO SIGN* | DATE

PARENT / LEGAL GUARDIAN - *REQUIRED IF PATIENT IS LESS THAT 18 YEARS OF AGE OR IS NOT LEGALLY COMPETENT*

ADDRESS, CITY, STATE, ZIP | HOME PHONE NUMBER ( )

EMPLOYER | WORK PHONE NUMBER ( )

WITNESS - *SIGNATURE* | DATE

Authorization to Release Protected Health Information, Assign Benefits, and Accept Responsibility for My Account: I authorize any physician or laboratory who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Center for Genetic Testing at Saint Francis. I understand that I am responsible for any co-pay or deductible amounts if the Center for Genetic Testing at Saint Francis is a participant in my health plan. I understand I am fully responsible for payment of my account if the Center for Genetic Testing at Saint Francis is not a participant with my health plan, and my health plan does not reimburse (or only partially reimburses) my medical services due to lack of authorization or medical necessity. **The information permitted for release may include records which indicate the presence of a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS), and/or mental health information.**

PATIENT / GUARANTOR - *SIGNATURE* | DATE

☐ **REFERRING FACILITY**

FACILITY NAME | PHONE NUMBER ( ) | FAX NUMBER ( )

BILLING ADDRESS | APPROVAL NUMBER - *IF APPLICABLE*

☐ **OSDH**

AUTHORIZATION NUMBER