



Children's Hospital Colorado

Children's Hospital Colorado
Department of Pathology & Laboratory Medicine
Precision Diagnostics Lab - Inherited Genetic Disease Requisition
Phone (720) 777-6711
Fax (720) 777-7118

Specimen Shipping Address:
Children's Hospital Colorado
Clinical Laboratory - Room B0200
13123 E. 16th Ave
Aurora, CO 80045

FAILURE TO COMPLETE BELOW FIELDS WILL DELAY RESULTS

\*\*PLEASE PROVIDE COMPLETE BILLING INFORMATION\*\*

Ordering Institution Name:
Ordering Institution Address:
Street:
City, State, Zip:
Ordering Provider (Last, First, and Middle Initial):
Ordering Provider Phone:
Result Contact Name:
Result Phone:
Result Fax:
Client Specimen Label
Internal Specimen Label

Patient Information

Last Name
First Name
Middle Initial
Birthdate (MM/DD/YYYY)
Sex
Client Medical Record Number
Client Specimen Number
Diagnosis/ICD-10 Code

Specimen Information

Date Collected (MM/DD/YYYY)
Time Collected (HHMM) AM/PM
Fetal Sample (Specify Source Below)
Gestational Age
Cord Blood
CVS Direct
Amniotic Fluid Direct
CVS Tissue Culture
Amniotic Fluid Tissue Culture
Blood
Tissue-FFPE Source
Bone Marrow
Tissue-Frozen Source
Nail Clippings
Tissue-RPMI Bone Marrow Core, Source: Bone Marrow Biopsy Source
Extracted DNA
Tissue-RPMI Source
Extracted RNA
Buccal Swab
Other:

Additional Information

FAILURE TO COMPLETE BELOW FIELDS WILL DELAY RESULTS

Bill To: Submitter/Client

Billing Contact Information:
Name:
Email:
Phone:
Insitution Name:
Address (incl. City, State, Zip):
Phone:
Fax:
Billing Facility and Address same as Submitter Listed

Bill To: Patient Insurance

\*\*\*\*If below items are not included WITH the specimen, the referring provider will be billed directly and responsible for payment\*\*\*\*
A face and or demographic sheet with the following criteria MUST be provided:

- Patients Full Name
- Patients Full Address (City, State
- Patients Phone Number
- Patients Insurance Name and Plan Type (Primary and Secondary)
- Policy/ID Number
- If Subscriber is different than patient - a DOB is REQUIRED

1 If submitting fetal/prenatal specimen, a maternal specimen for MCC testing is also required. Please complete maternal sample section on the back of this page. 2 I attest that the extracted nucleic acid has been isolated in a CLIA-certified laboratory or a laboratory deemed equivalent by CAP/CMS.



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Client

Next Generation Sequencing (SNV, indels, and copy number variants)

Methylmalonic Acidemia and Homocystinuria Panel LAB8614 Noonan Spectrum Disorders/RASopathies Panel LAB8613
33 gene panel AHCY, ABCD4, ACSF3, ALDH6A1, AMN, CBS, CD320, CUBN, GIF, GNMT, HCFC1, IVD, LMBRD1, MAT1A, MCEE, MMAA, MMAB, MMACHC, MMADHC, MTHFD1, MTHFR, MTR, MTRR, MUT, SLC46A1, SUCLA2, SUCLG1, TCN1, TCN2, MLYCD, PRDX1, THAP11, ZNF143
32 gene panel A2ML1, ACTB, ACTG1, BRAF, CBL, CDC42, EPHB4, HRAS, KAT6B, KRAS, LZTR1, MAP2K1, MAP2K2, MAP3K8, MRAS, NF1, NRAS, NSUN2, PPP1CB, PTPN11, RAF1, RASA1, RASA2, RIT1, RRAS, SASH1, SHOC2, SMARCB1, SOS1, SOS2, SPRED1, STAMBP

Nonketotic Hyperglycinemia Panel LAB9148 Single Gene Sequence Analysis (SNV, indels, and copy number variants)3 LAB7981 Indicate Gene:

13 gene panel AMT, BOLA3, GCSH, GLDC, GLRX5, IBA57, MECR, LIAS, LIPT1, LIPT2, NFU1, SLC25A26, SLC6A9 Custom Panel (2 - 50 Genes) LAB9094 Indicate genes in 'Additional Information' Section

CHILD Panel4 include Fragile X FMR-1 Analysis LAB9571 Exome Analysis4 LAB8650
Proband Only
Familial Analysis - Must Complete Familial Testing Section

Panel Reflex to Exome Analysis

Original Specimen ID: Use all family members from original panel
Original Panel: Update family members to be tested (Must Complete Familial Testing Section) LAB9096

Maternal Sample for Maternal Cell Contamination - REQUIRED FOR ANY PRENATAL TESTING

Date Collected (MM/DD/YY) Specimen Source: Blood Swab
Time Collected (HHMM) AM / PM Other: LAB7663

Familial Testing Information (Up to 4 additional samples)

Reason for Testing: Diagnostic Carrier Testing Prenatal (Maternal Cell Contamination Testing Required)
Clinical Indication for Testing:
Relationship to Proband: Proband Only Analysis Mother Father Sibling Other(specify):
Sex:
Legal Name:
Date of Birth:
Clinically Affected: Yes No Unknown
Report ACMG secondary findings regardless of primary reason for testing? Yes No

Fragment Analysis or Sanger Sequencing

Fragile X FMR1 CGG Repeats (includes Southern blot if positive) LAB6943
Factor V Leiden (G1691A) and Prothrombin (20210A) Mutations LAB8455
Targeted Known Familial Analysis vis Sanger Sequencing (Up to 5 targets)3 4 LAB8635

Known Variant 1 Additional target information should be written in the section below.
Gene: Chromosomal Position: (Ex. chr7: 117509047) Family ID (if known ex: FIN123):
Transcript ID: (Ex: NM\_123456.1) c.DNA Change: (Ex. c.178Gly>Ala or c.178G>A) Protein Change: (Ex. p.Glu60Lys or p.E60K)

Additional Information

Pedigree, Clinical Information or Special Instructions (attach pedigree):

Signature of Consent Required for All Laboratory Testing:
I certify that the patient specified above and/or their legal guardian has been informed of the benefits risks and limitations of the laboratory test(s) requested. I have answered all questions and have obtained informed consent from the patient or their legal guardian for this testing.

Name: Signature: Date:

3 Charges applicable per gene. 4 Gene list available upon request.