Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Molecular Genetics Laboratory
VANSeq and SpotSeq

4800 Sand Point Way NE FB.2.441
Seattle, WA 98105 (206) 987-2617

FAILURE TO COMPLETE MAY DELAY RESULTS

Patient's Last Name	First	Middle	Birth date	Sex

Outside Patient Number	Outside Specimen Number	Send Report To:

Ordering Provider	Address:

Provider Phone Number	DIAGNOSIS / ICD CODE:	Phone:	Fax:

IMPORTANT INFORMATION REGARDING BILLING AND MEDICAL NECESSITY ON LAST PAGE

HEALTHCARE PROFESSIONAL TO CALL FOR INFO/ABNORMAL RESULTS:
NAME: PHONE #:

FAX ADDITIONAL RESULTS TO:
NAME: FAX #:

SPECIMEN INFORMATION

Date collected: _____ Time collected: _____

ALL SPECIMENS MUST BE LABELED WITH A MINIMUM OF TWO UNIQUE IDENTIFIERS

- ☐ Blood
- ☐ Saliva (OrageneDx OGD-575/675 only)
- ☐ Cord Blood
- ☐ Extracted gDNA from blood (select one)
  - ☐ EDTA ☐ ACD
- ☐ Cell Free DNA (collection in Streck tube)
  - ☐ Lymphatic **cyst** fluid ☐ Peripheral blood
  - ☐ Lesional blood
  - **CELL FREE DNA ACCEPTED FOR SPOTSEQ ONLY**

PATHOLOGY REPORT IS REQUIRED FOR FFPE TISSUE AND REQUESTED FOR OTHER TISSUE

Tissue source (Exact Anatomical Site): _____

- ☐ Fresh Tissue
- ☐ Extracted DNA from fresh tissue
- ☐ Frozen Tissue
- ☐ Extracted DNA from frozen tissue
- ☐ FFPE Tissue
- ☐ Extracted DNA from FFPE tissue

Please note FFPE is not accepted for Del/Dup or SpotSeq testing.

PATIENT/FAMILY HISTORY REQUIRED - ATTACH RELEVANT CLINIC NOTES

Clinical information provided will aid in interpretation, decrease testing delays and improve reporting.

REASON FOR STUDY: ☐ Diagnostic (affected) ☐ Diagnostic (not affected) ☐ Carrier Testing (affected family member) ☐ Carrier Testing (no family history)

CLINICAL FINDINGS, FAMILY HISTORY: _____

RELEVANT PREVIOUS GENETIC TEST RESULT(S): _____

ETHNICITIES: _____ **PATIENT PREGNANT?** ☐ No ☐ Yes, estimated due date: _____

MOLECULAR ANALYSIS

Test information, specimen and shipping requirements & gene lists available at: http://seattlechildrenslab.testcatalog.org

For reflex testing, check all boxes that apply. Sequencing will be peformed before deletion/duplication, unless otherwise specified.

Test code	VASCULAR ANOMALIES (VANSeq) Panels	
LAB1920	☐ PIK3CA Targeted Gene Seq	
LAB1821	☐ Cerebral Cavernous Malformations Seq Panel	☐ Del/Dup
LAB1844	☐ ECCL/OES Sequencing	☐ Del/Dup
LAB1856	☐ Hereditary Hemorrhagic Telangiectasia Seq Panel	☐ Del/Dup
LAB1920	☐ VANSeq-Capillary Malformations Seq Panel	☐ Del/Dup
LAB1920	☐ VANSeq-Lymphatic/Venous/AVM Seq Panel	☐ Del/Dup
LAB1920	☐ VANSeq-Lymphedema Seq Panel	☐ Del/Dup
LAB1920	☐ VANSeq-Vascular Tumor Seq Panel	☐ Del/Dup
LAB1920	☐ VANSeq-Expanded Seq Panel	☐ Del/Dup

TARGETED GENE ANALYSIS from VANSeq Panels

Target gene(s) must be specified: _____

- LAB3617 ☐ Targeted Gene Sequencing by NGS
- LAB3616 ☐ Targeted Gene Deletion/Duplication by Array

Test code	HIGH SENSITIVITY ALLELE SPECIFIC ASSAYS (SpotSeq)
LAB3822	☐ PIK3CA Hotspot multiplex: E542K, E545K, H1047R
	☐ TEK L914F
	☐ GNAQ R183Q
	☐ BRAF V600E

Please note FFPE is not accepted for SpotSeq testing.

TARGETED GENE VARIANT ANALYSIS**

****Targeted testing is available only for family follow-up of individuals previously tested at Seattle Children's Hospital Genetics Lab.**
All below fields are required.**

LAB1915
- Gene: _____
- Variant(s): _____
- Proband Name: _____
- Relationship to Proband: _____

BILLING INFORMATION

PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

BILLING NOTIFICATION: All samples will be billed to the referring institution unless complete billing and diagnosis information is provided on this form. Contact Seattle Children's Laboratory Client Services for additional assistance (206) 987-2617.

BILL TO:

☐ **Referring Institution (Preferred)** - Provide billing address or stamp institution's information.
(Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients.)

Billing Address:	Billing Contact:
Billing Contact Phone/Fax:	Billing Contact Email:

☐ **Primary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		Employer
Primary Care Physician		Phone Number
Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Secondary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Self Pay**- First, call Lab Client Services for pricing. Then, provide credit card information below or enclose a check with the sample.

Patient Address			
Guarantor Name	DOB	Relationship to Patient	
Guarantor Address (if different from patient's)			
Guarantor Phone (if different from patient's)			
Name on Credit Card		Payment Amount	CVN
Card Number		Card Type	Expiration

Please visit our test catalog at http://seattlechildrenslab.testcatalog.org for testing information or call:
Lab Genetic Counselors (206) 987-5400 Lab Client Services (206) 987-2617

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Ship to: LABORATORY
4800 Sand Point Way NE, M/S: FB.2.241
SEATTLE, WA 98105