

FAILURE TO COMPLETE MAY DELAY RESULTS

Patient's Last Name	First	Middle	Birth Date (Required)	Legal Sex	Gender Identity
Outside Patient Number	Outside Specimen Number	Send Report To:			
Ordering Provider			Address:		
Provider Phone#/Email	Diagnosis/ICD10 Code (Required)	Phone:	Fax:		

IMPORTANT INFORMATION REGARDING BILLING AND MEDICAL NECESSITY ON LAST PAGE

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

SPECIMEN INFORMATION

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

Date collected: _____

Time collected: _____

Blood
 Extracted gDNA from blood (select one) EDTA ACD
 Saliva (OrageneDx OGD-575/675 only)

FOR SPOTSEQ ONLY (collection in Streck tube)

Lymphatic cyst fluid Peripheral blood
 Lesional blood

INCLUDE A COPY OF THE PATHOLOGY REPORT FOR ALL FFPE TISSUE AND ANY FRESH TISSUE WHERE PATHOLOGY WAS PERFORMED

Tissue source **required** (Exact Anatomical Site): _____

Fresh Tissue Fresh Frozen Tissue FFPE Tissue Slides Scrolls Block/cassette
 Extracted DNA from fresh tissue Extracted DNA from frozen tissue Extracted DNA from FFPE tissue

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): _____

PATIENT PREGNANT? No Yes, estimated due date: _____

MOLECULAR ANALYSIS

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

Reflex to VANseq Expanded Panel is available if indicated. Reflex between focused panels is not available. Sequencing will be performed before deletion/duplication, unless otherwise specified. Please note FFPE is not accepted for Del/Dup or SpotSeq testing.

Test code	VASCULAR ANOMALIES (VANSeq) Panels	Test code	HIGH SENSITIVITY ALLELE SPECIFIC ASSAYS (SpotSeq)
LAB1821	<input type="checkbox"/> Cerebral Cavemous Malformations Seq Panel <input type="checkbox"/> Del/Dup	Selecting multiple SpotSeq targets is NOT generally recommended.	
LAB1844	<input type="checkbox"/> ECCL/OES Sequencing	LAB3822	<input type="checkbox"/> PIK3CA Hotspot multiplex: E542K, E545K, H1047R
LAB1920	<input type="checkbox"/> PIK3CA Targeted Gene Seq	LAB3822	<input type="checkbox"/> TEK L914F
LAB1920	<input type="checkbox"/> VANSeq-Capillary Malformations Seq Panel <input type="checkbox"/> Del/Dup	LAB3822	<input type="checkbox"/> GNAQ R183Q See lab test catalog for more info
LAB1920	<input type="checkbox"/> VANSeq-Lymphatic/Venous/AVM Seq Panel <input type="checkbox"/> Del/Dup	LAB3822	<input type="checkbox"/> BRAF V600E
LAB1920	<input type="checkbox"/> VANSeq-Lymphedema Seq Panel <input type="checkbox"/> Del/Dup	TARGETED VARIANT ANALYSIS**	
LAB1920	<input type="checkbox"/> VANSeq-Vascular Tumor Seq Panel <input type="checkbox"/> Del/Dup	**Targeted testing is available <u>only</u> for family follow-up of individuals	
LAB1920	<input type="checkbox"/> VANSeq-Expanded Seq Panel <input type="checkbox"/> Del/Dup	previously tested at Seattle Children's Hospital Genetics Lab.	
LAB1920	<input type="checkbox"/> Reflex to VANSeq-Expanded Seq Panel if primary test is non-diagnostic	LAB1915	<input type="checkbox"/> Gene: _____

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

All fields required. 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 Name:
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