

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				
Phone Number	Diagnosis/ICD Code (Required)	Phone/Fax			

REQUIRED SPECIMEN INFORMATION:

DATE COLLECTED: ____/____/____ Whole Blood Serum/Plasma Urine
 TIME COLLECTED: ____:____ AM/PM Skin Other _____

BLOOD

- | | |
|--|---|
| <input type="checkbox"/> ACYLCARNITINE PROFILE, BLOOD (LAB429) | <input type="checkbox"/> METHYLMALONIC ACID, QUANTITATIVE (LAB835) |
| <input type="checkbox"/> AMINO ACID, QUANTITATIVE (LAB811) | <input type="checkbox"/> MSUD MONITORING (LAB1956) |
| <input type="checkbox"/> SINGLE AMINO ACID, SPECIFY: | <input type="checkbox"/> NITISINONE (NTBC) LEVEL (LAB3358) |
| <input type="checkbox"/> ALPHA-AMINOADIPIC SEMIALDEHYDE (needs STAT processing, LAB2771) | <input type="checkbox"/> PHENYLALANINE/TYROSINE, QUANTITATIVE (LAB3371) |
| <input type="checkbox"/> FREE AND TOTAL CARNITINE, PLASMA (LAB2896) | <input type="checkbox"/> PIPECOLIC ACID (LAB3379) |
| <input type="checkbox"/> GALACTOSE-1-PHOSPHATE URIDYLTRANSFERASE (GALACTOSEMIA, LAB994) | <input type="checkbox"/> VERY LONG CHAIN FATTY ACIDS, PHYTANIC, PRISTANIC (LAB3544) |
| <input type="checkbox"/> GALACTOSE-1-PHOSPHATE, QUANTITATIVE (LAB995) | <input type="checkbox"/> BIOTINIDASE (LAB958) |

LYSOSOMAL ENZYMES by DISEASE

- | | |
|--|--|
| <input type="checkbox"/> CEROID LIPOFUSCINOSIS-CLN1 (palmitoyl-protein thioesterase, L, F, DBS, LAB3364) | <input type="checkbox"/> MORQUIO (galactose-6-sulfatase, MPS IVa, L, F, LAB3066) |
| <input type="checkbox"/> CEROID LIPOFUSCINOSIS-CLN2 (tripeptidyl peptidase, L, F, DBS, LAB3521) | <input type="checkbox"/> I CELL DISEASE (Hexosaminidase, A&B, Arylsulfatase A, S, P, I CELL) |
| <input type="checkbox"/> FABRY (alpha-galactosidase, L, F, DBS, LAB2773) | <input type="checkbox"/> MANNOSIDOSIS (alpha-mannosidase, L, F, LAB2778) |
| <input type="checkbox"/> FUCOSIDOSIS (alpha-fucosidase, L, F, LAB2772) | <input type="checkbox"/> MANNOSIDOSIS (beta-mannosidase, L, F, LAB2843) |
| <input type="checkbox"/> GAUCHER (beta-glucosidase, L, F, LAB2840) | <input type="checkbox"/> MAROTEAX-LAMY (Arylsulfatase B, L, F, LAB2818) |
| <input type="checkbox"/> GM1 GANGLIOSIDOSIS (beta-galactosidase, L, F, LAB2839) | <input type="checkbox"/> MLD (Arylsulfatase A, L, F, LAB2816) |
| <input type="checkbox"/> GM2 GANGLIOSIDOSIS (Tay Sachs, Sandhoff, Hexosaminidase A+B, F, S, LAB3165) | <input type="checkbox"/> POMPE (alpha-glucosidase, acid maltase, F, DBS, LAB2774) |
| <input type="checkbox"/> HUNTER (Iduronate-2-sulfatase, S, P, LAB3201) | <input type="checkbox"/> SLY (beta-glucuronidase, L, F, LAB2841) |
| <input type="checkbox"/> HURLER (alpha-iduronidase, L, F, LAB2777) | <input type="checkbox"/> WOLMAN, CHOLESTERYL ESTER STORAGE (lysosomal acid lipase, DBS, LAB2701) |
| <input type="checkbox"/> KRABBE (galactocerebrosidase, L, F, LAB3065) | |

F=Fibroblasts DBS=Dried Blood Spot L=Leukocytes M=Muscle P=Plasma S=Serum

FIBROBLASTS/TISSUE

- | | |
|---|--|
| <input type="checkbox"/> FIBROBLAST CULTURE (LAB1804) | <input type="checkbox"/> MITOCHONDRIAL RESPIRATORY CHAIN ENZYME ANALYSIS (M) |
|---|--|

URINE

- | | |
|--|--|
| <input type="checkbox"/> AMINO ACIDS, QUANTITATIVE URINE (LAB355) | <input type="checkbox"/> PHOSPHOETHANOLAMINE QUANTITATIVE, URINE (LAB1962) |
| <input type="checkbox"/> CYSTINE, QUANTITATIVE URINE (LAB387) | <input type="checkbox"/> SUCCINYLACETONE QUANTITATION, URINE (LAB1964) |
| <input type="checkbox"/> FREE AND TOTAL CARNITINE, URINE (LAB1941) | <input type="checkbox"/> SULFHYDRYL GROUPS, QUALITATIVE URINE (LAB1966) |
| <input type="checkbox"/> MUCOPOLYSACCHARIDE, QUANTITATIVE URINE (LAB1057) | <input type="checkbox"/> SULFITE, DIPSTICK URINE (LAB1967) |
| <input type="checkbox"/> ORGANIC ACIDS, URINE (LAB418) | |
| <input type="checkbox"/> SUCCINYLACETONE SCREENING, ORGANIC ADD-ON (LAB1965) | |

PATIENT INFORMATION

DRUGS ADMINISTERED WITHIN PREVIOUS 72 HOURS:

PATIENT HISTORY: Seizures Metabolic Disease Developmental Delay Renal Disease Liver Disease Hepatomegaly Dyslipidemia
 Other: _____

CLINICAL HISTORY/REASON FOR SUBMITTING SAMPLE:

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 Client Services (206) 987-2617 Biochemical Genetics Lab (206) 987-2216