

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 BACK

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

SPECIMEN INFORMATION

Date collected: _____ Specimen: Blood, EDTA or ACD Extracted DNA, source: _____
 Time collected: _____ Saliva (OrageneDx OGD-575/675 only) Tissue, fresh frozen or FFPE, source: _____

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, PREVIOUS RELEVANT GENETIC TEST RESULT(S), FAMILY HISTORY: _____

ETHNICITY: _____ **PATIENT PREGNANT?** NO YES Estimated due date: _____

DNA ANALYSIS

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

For reflex testing, check all boxes that apply:

CRANIOSYNOSTOSIS

- Craniosynostosis Seq - Focused Panel - 7 genes Deletion/Duplication Analysis
 Craniosynostosis Seq - Expanded Panel - 49 genes

DIABETES

- Congenital Hyperinsulinism (CHI) Sequencing Panel - 9 genes
 Maturity Onset Diabetes of the Young (MODY) Sequencing Panel - 15 genes
 Neonatal Diabetes (NDM) Sequencing Panel - 23 genes
 Deletion/Duplication Analysis

DIFFERENCES IN SEX DEVELOPMENT (DSD)

- DSD Sequencing Panel - 56 genes Deletion/Duplication Analysis

ENCEPHALOCRANIOCUTANEOUS LIPOMATOSIS/OCULOECTODERMAL SYNDROME

- ECCL/OES Sequencing (FGFR1/KRAS) Panel - 2 genes

INTERSTITIAL LUNG DISEASE

- Childhood Interstitial Lung Disease (chILD) Sequencing - Expanded Panel - 48 genes
 chILD Seq - Rapid Neonatal Panel - 9 genes
 Deletion/Duplication Analysis

INTESTINAL PSEUDO-OBSTRUCTION

- Intestinal Pseudo-Obstruction Seq Panel - 12 genes Deletion/Duplication Analysis

RETT/ANGELMAN SYNDROME

- Rett/Angelman Syndrome Seq Panel - 16 genes Deletion/Duplication Analysis

VASCULAR ANOMALIES

- Cerebral Caverosus Malformations (CCM) Sequencing Panel - 3 genes
 Hereditary hemorrhagic telangiectasia (HHT) Sequencing Panel - 6 genes
 VANSeq - Capillary Malformation Panel - 4 genes
 VANSeq - Lymphatic/Venous/Arteriovenous Malformations (LM/VM/AVM) Panel - 17 genes
 VANSeq - Lymphedema Panel - 23 genes
 VANSeq - Vascular Tumor Panel - 10 genes
 VANSeq - Expanded Panel - 44 genes

Common VANSeq single gene request:

- PDGFRB Seq - Isolated aneurysm/infantile myofibromatosis/Penttinen syndrome
 PIK3CA related overgrowth spectrum (PIK3CA) Sequencing
 Deletion/Duplication Analysis

- 22q11.2 Deletion/Duplication by MLPA (22q11.2 DS, DiGeorge, VCFS)
 Connexin 26/30 (GJB2 Sequencing with reflex to common deletion analysis of GJB6)
 Connexin 30 (GJB6) Sequencing
 Fragile X DNA (FMR1)
 Galactosemia (GALT) Common Variants Panel (8 variants)
 Gaucher Disease (GBA) Panel (11 variants)
 Gaucher (GBA) Sequencing
 LCHAD/TFP (HADHA) Sequencing
 LCHAD/TFP (HADHB) Sequencing
 Lysosomal Acid Lipase (LIPA) Sequencing (Wolman Disease/CESD)
 MCAD (ACADM) Sequencing
 Pendred (SLC26A4) Sequencing
 Polymerase Gamma (POLG) Sequencing
 Polymerase Gamma 2 (POLG2) Sequencing
 Pompe (GAA) Sequencing
 Prader-Willi/Angelman Methylation and Deletion/Duplication by MS-MLPA
 Primary Hyperoxaluria Type 1 (AGXT) Sequencing
 Pyridoxine-Dependent Seizures (ALDH7A1) Sequencing
 Spinal Muscular Atrophy Diagnostic (SMN1 & SMN2 copy number)
 Spinal Muscular Atrophy Carrier Testing (SMN1 copy number)
 Tyrosinemia type 1 (FAH) Panel (6 variants)
 VLCAD (ACADVL) Sequencing
 Wilson Disease (ATP7B) Sequencing

SINGLE GENE ANALYSIS from SCH panels

- Sequencing Deletion/Duplication Analysis

GENE(S): _____

TARGETED VARIANT ANALYSIS (Information Below is Required for this Testing)

GENE: _____

VARIANT(S): _____

PROBAND*: _____ **RELATIONSHIP:** _____

*If relative was not tested at Seattle Children's Laboratory, please contact the Laboratory Genetic Counselors (206-987-5400) for approval of testing prior to submitting samples.

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

Molecular Genetics Lab (206) 987-3872



Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Ship to: LABORATORY
4800 Sand Point Way NE, M/S: OC.8.720
SEATTLE, WA 98105