Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Molecular and Cytogenetics Laboratory

Department of Laboratories
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 **(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

CLINICIAN TO CONTACT 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
- ☐ Cord Blood
- ☐ Extracted gDNA from blood
  - ☐ EDTA ☐ ACD
- ☐ Saliva (OrageneDx OGD-575/675 only)
- ☐ Fresh Tissue
  - Tissue source (Exact Anatomical Site): _____

FOR SCH LAB USE: ☐ Room Temp ☐ Refrig ☐ Frozen

Container(s) received: ☐ EDTA ☐ NaHep ☐ Sterile cup/cryovial ☐ DNA tube ☐ Saliva ☐ Other: _____

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

Testing performed by next-generation sequencing (NGS) analyzed to identify both sequence and copy number variants.

Test code	CHILDHOOD INTERSTITIAL LUNG DISEASE (ChILD) Panel
LAB1825	☐ ChILD Expanded Seq Panel
	DIABETES Panels
LAB2943	☐ Congenital Hyperinsulinism Seq Panel
LAB1884	☐ Maturity Onset Diabetes of the Young Seq Panel
LAB1885	☐ Neonatal Diabetes Seq Panel
	HEREDITARY HEMORRHAGIC TELANGIECTASIA Panel
LAB1856	☐ Hereditary Hemorrhagic Telangiectasia Seq Panel
	IMMUNODEFICIENCY (ImmuneSeq) Panels
LAB3799	☐ ImmuneSeq Autoimmune Lymphoproliferative Syndrome (ALPS)
LAB3800	☐ ImmuneSeq Familial Hemophagocytic Lymphohistiocytosis (FHLH)
LAB3904	☐ ImmuneSeq Primary Ciliary Dyskinesia (PCD) Panel
LAB3798	☐ ImmuneSeq Severe Combined Immunodeficiency (SCID)
LAB3801	☐ ImmuneSeq (VEO-IBD)/Early Onset Enteropathy
LAB3797	☐ ImmuneSeq Expanded Panel
	INTESTINAL PSEUDO-OBSTRUCTION Panel
LAB1866	☐ Intestinal Pseudo-Obstruction Seq Panel

Test code	CRANIOSYNOSTOSIS Panels
LAB1835	☐ Craniosynostosis Focused Seq Panel
LAB1835	☐ Craniosynostosis Expanded Seq Panel
	DIFFERENCES IN SEX DEVELOPMENT (DSD) Panel
LAB1840	☐ Differences in Sex Dev Seq Panel
	TARGETED GENE ANALYSIS from SCH Panels
	Target gene(s) must be specified: _____
LAB3617	☐ Targeted Gene Sequencing by NGS
LAB3616	☐ Targeted Gene Deletion/Duplication by Array
	MOLECULAR FAMILY FOLLOW-UP STUDY**

****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 ☐ Targeted Gene Variant:

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

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

Test code	OTHER MOLECULAR ANALYSIS
LAB1808	☐ 22q11.2 Deletion/Duplication by MLPA (22q11.2 DS, DiGeorge, VCFS)
LAB1847	☐ Fragile X DNA (FMR1)
LAB1894	☐ Prader-Willi/Angelman Methylation & CNV Analysis
LAB1912	☐ Spinal Muscular Atrophy Diagnostic (SMN1 & SMN2 Copy Number)
LAB1911	☐ Spinal Muscular Atrophy Carrier Test (SMN1 copy number)

Test code	BIOCHEMICAL GENETICS MOLECULAR ANALYSIS
LAB3912	☐ Galactosemia DNA Analysis (GALT 8 Common Variants Panel)
LAB1877	☐ MCAD (ACADM) Sequencing
LAB1892	☐ Pompe (GAA) Sequencing
LAB1921	☐ VLCAD (ACADVL) Sequencing
LAB1926	☐ Wilson Disease (ATP7B) Sequencing

Test code	ARRAY ANALYSIS
LAB1803	☐ Chromosomal SNP Microarray

Test code	CYTOGENETIC ANALYSIS
LAB1797	☐ Constitutional karyotype - Mosaic Study (30 cells)
LAB1797	☐ Constitutional karyotype - Routine (20 cells)
LAB1797	☐ Constitutional karyotype - Limited Study (5 cells)
LAB1800	☐ Constitutional FISH (Fluorescence *in situ* hybridization) for SRY Sex Determination
LAB1804	☐ Fibroblast Culture
LAB1804	☐ Fibroblast Culture and Storage (Cryopreservation)

** ☐ Preliminary karyotype notification requested (24-72 hours).

- Only available for infants <2 weeks of age.
- Minimum sample volume: 1.5mL.
- Additional charge applies.

Contact Name (Required):_____

Contact Number (Required):_____

CYTO/ARRAY FAMILY FOLLOW-UP STUDY***

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

Proband control specimen may be required. Consult with laboratory genetic counselors prior to placing order if uncertain.

Proband Name (Required): _____

Relationship to Proband (Required): _____

Test (indicated on Proband report):

LAB3622 ☐ Family Study Karyotype
LAB3621 ☐ Family Study FISH
LAB3625 ☐ Family Study qPCR
LAB3623 ☐ Family Study Chromosomal SNP Microarray

LAB3682 ☐ Proband Control specimen for:

Family Member Name (Required): _____

Relationship to Family Member (Required): _____

Check test that will be performed on family member:

☐ Family Study Karyotype
☐ Family Study FISH
☐ Family Study qPCR
☐ Family Study Chromosomal SNP Microarray

See Page 3 for Billing Information

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

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Ship to: LABORATORY
4800 Sand Point Way NE, M/S: FB.2.441
SEATTLE, WA 98105