

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:	EMAIL:	PHONE #:	NAME:	FAX #:	

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

Date collected: _____ Time collected: _____

<input type="checkbox"/> Blood	<input type="checkbox"/> Saliva (OrageneDx OGD-575/675 only)	<input type="checkbox"/> Fresh Tissue
<input type="checkbox"/> Cord Blood	Tissue source (Exact Anatomical Site): _____	
<input type="checkbox"/> Extracted gDNA from blood		
<input type="checkbox"/> EDTA <input type="checkbox"/> ACD		

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	Test code	IMMUNODEFICIENCY (ImmuneSeq) Panels
LAB1825	<input type="checkbox"/> ChILD Expanded Seq Panel	LAB3799	<input type="checkbox"/> ImmuneSeq Autoimmune Lymphoproliferative Syndrome (ALPS)
CRANIOSYNOSTOSIS Panels		LAB3798	<input type="checkbox"/> ImmuneSeq Severe Combined Immunodeficiency (SCID)
LAB1835	<input type="checkbox"/> Craniosynostosis Focused Seq Panel	LAB3800	<input type="checkbox"/> ImmuneSeq Familial Hemophagocytic Lymphohistiocytosis (FHLH)
LAB1835	<input type="checkbox"/> Craniosynostosis Expanded Seq Panel	LAB3801	<input type="checkbox"/> ImmuneSeq (VEO-IBD)/Early Onset Enteropathy
DIABETES Panels		LAB3797	<input type="checkbox"/> ImmuneSeq Expanded Panel
LAB2943	<input type="checkbox"/> Congenital Hyperinsulinism Seq Panel	TARGETED GENE ANALYSIS from SCH Panels	
LAB1884	<input type="checkbox"/> Maturity Onset Diabetes of the Young (MODY)Seq Panel	Target gene(s) must be specified: _____	
LAB1885	<input type="checkbox"/> Neonatal Diabetes Seq Panel	LAB3617	<input type="checkbox"/> Targeted Gene Sequencing by NGS
DIFFERENCES IN SEX DEVELOPMENT (DSD) Panel		LAB3616	<input type="checkbox"/> Targeted Gene Deletion/Duplication by Array
LAB1840	<input type="checkbox"/> Differences in Sex Dev Seq Panel	MOLECULAR FAMILY FOLLOW-UP STUDY**	
HEREDITARY HEMORRHAGIC TELANGIECTASIA Panel		**Targeted testing is available <u>only</u> for family follow-up of individuals previously tested at Seattle Children's Hospital Genetics Lab. All below fields are <u>required</u>.	
LAB1856	<input type="checkbox"/> Hereditary Hemorrhagic Telangiectasia Seq Panel	LAB1915	<input type="checkbox"/> Targeted Gene Variant:
INTESTINAL PSEUDO-OBSTRUCTION Panel		Gene: _____	
LAB1866	<input type="checkbox"/> Intestinal Pseudo-Obstruction Seq Panel	Variant(s): _____	
RETT/ANGELMAN SYNDROME Panel		Proband Name: _____	
LAB1898	<input type="checkbox"/> Rett/Angelman Syndrome Seq Panel	Relationship to Proband: _____	

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

Test code OTHER MOLECULAR ANALYSIS		Test code BIOCHEMICAL GENETICS MOLECULAR ANALYSIS	
LAB1808	<input type="checkbox"/> 22q11.2 Deletion/Duplication by MLPA (22q11.2 DS, DiGeorge, VCFS)	LAB1849	<input type="checkbox"/> Galactosemia DNA Analysis (GALT 8 Common Variants Panel)
LAB1847	<input type="checkbox"/> Fragile X DNA (FMR1)	LAB1850	<input type="checkbox"/> Gaucher Disease Panel (11 variants)
LAB1894	<input type="checkbox"/> Prader-Willi/Angelman Methylation & CNV Analysis	LAB1850	<input type="checkbox"/> Gaucher DNA Sequencing (GBA)
LAB1912	<input type="checkbox"/> Spinal Muscular Atrophy <u>Diagnostic</u> (SMN1 & SMN2 Copy Number)	LAB1870	<input type="checkbox"/> LCHAD/TFP (HADHA) Sequencing
LAB1911	<input type="checkbox"/> Spinal Muscular Atrophy <u>Carrier</u> Test (SMN1 copy number)	LAB1870	<input type="checkbox"/> LCHAD/TFP (HADHB) Sequencing
		LAB1872	<input type="checkbox"/> Lysosomal Acid Lipase (LIPA) Sequencing (Wolman Disease/CESD)
		LAB1877	<input type="checkbox"/> MCAD (ACADM) Sequencing
		LAB1889	<input type="checkbox"/> Polymerase Gamma (POLG) Sequencing
		LAB1891	<input type="checkbox"/> Polymerase Gamma 2 (POLG2) Sequencing
		LAB1892	<input type="checkbox"/> Pompe (GAA) Sequencing
		LAB1862	<input type="checkbox"/> Primary Hyperoxaluria Type 1 (AGXT) Sequencing
		LAB1811	<input type="checkbox"/> Pyridoxine-Dependent Seizures (ALDH7A1) Sequencing
		LAB3530	<input type="checkbox"/> Tyrosinemia type 1 (FAH) Panel (6 variants)
		LAB1921	<input type="checkbox"/> VLCAD (ACADVL) Sequencing
		LAB1926	<input type="checkbox"/> Wilson Disease (ATP7B) Sequencing
Test code ARRAY ANALYSIS		CYTO/ARRAY FAMILY FOLLOW-UP STUDY***	
LAB1803	<input type="checkbox"/> Chromosomal SNP Microarray	<p>***Targeted testing is available <u>only</u> for family follow-up of individuals previously tested at Seattle Children's Hospital Genetics Lab.</p> <p>Proband control specimen may be required. Consult with laboratory genetic counselors prior to placing order if uncertain.</p> <p>Proband Name (Required): _____</p> <p>Relationship to Proband (Required): _____</p> <p>Test (indicated on Proband report):</p>	
Test code CYTOGENETIC ANALYSIS		<p>LAB3622 <input type="checkbox"/> Family Study Karyotype</p> <p>LAB3621 <input type="checkbox"/> Family Study FISH</p> <p>LAB3625 <input type="checkbox"/> Family Study qPCR</p> <p>LAB3623 <input type="checkbox"/> Family Study Chromosomal SNP Microarray</p> <p>LAB3682 <input type="checkbox"/> Proband Control specimen for: Family Member Name (Required): _____ Relationship to Family Member (Required): _____ Check test that will be performed on family member: <input type="checkbox"/> Family Study Karyotype <input type="checkbox"/> Family Study FISH <input type="checkbox"/> Family Study qPCR <input type="checkbox"/> Family Study Chromosomal SNP Microarray</p>	
LAB1797	<input type="checkbox"/> Constitutional karyotype - Mosaic Study (30 cells)		
LAB1797	<input type="checkbox"/> Constitutional karyotype - Routine (20 cells)		
LAB1797	<input type="checkbox"/> Constitutional karyotype - Limited Study (5 cells)		
LAB1800	<input type="checkbox"/> Constitutional FISH (Fluorescence <i>in situ</i> hybridization) for SRY Sex Determination		
LAB1804	<input type="checkbox"/> Fibroblast Culture		
LAB1804	<input type="checkbox"/> Fibroblast Culture and Storage (Cryopreservation)		

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