

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: _____

<input type="checkbox"/> Blood <input type="checkbox"/> Cord Blood <input type="checkbox"/> Extracted gDNA from blood <input type="checkbox"/> EDTA <input type="checkbox"/> ACD	<input type="checkbox"/> Saliva (OrageneDx OGD-575/675 only)	<input type="checkbox"/> Fresh Tissue Tissue source (Exact Anatomical Site): _____
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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 <input type="checkbox"/> ChILD Expanded Seq Panel DIABETES Panels LAB2943 <input type="checkbox"/> Congenital Hyperinsulinism Seq Panel LAB1884 <input type="checkbox"/> Maturity Onset Diabetes of the Young Seq Panel LAB1885 <input type="checkbox"/> Neonatal Diabetes Seq Panel HEREDITARY HEMORRHAGIC TELANGIECTASIA Panel LAB1856 <input type="checkbox"/> Hereditary Hemorrhagic Telangiectasia Seq Panel IMMUNODEFICIENCY Panels LAB3799 <input type="checkbox"/> Autoimmune Lymphoproliferative Syndrome (ALPS) Panel LAB3800 <input type="checkbox"/> Familial Hemophagocytic Lymphohistiocytosis (FHLH) Panel LAB3904 <input type="checkbox"/> Primary Ciliary Dyskinesia (PCD) Panel LAB3798 <input type="checkbox"/> Severe Combined Immunodeficiency (SCID) Panel LAB3801 <input type="checkbox"/> Very Early Onset Inflammatory Bowel Disease (VEO-IBD) Panel LAB3797 <input type="checkbox"/> ImmuneSeq Inborn Errors of Immunity Panel INTESTINAL PSEUDO-OBSTRUCTION Panel LAB1866 <input type="checkbox"/> Intestinal Pseudo-Obstruction Seq Panel	Test code CRANIOSYNOSTOSIS Panels LAB1835 <input type="checkbox"/> Craniosynostosis Focused Seq Panel LAB1835 <input type="checkbox"/> Craniosynostosis Expanded Seq Panel DIFFERENCES IN SEX DEVELOPMENT (DSD) Panel LAB1840 <input type="checkbox"/> Differences in Sex Dev Seq Panel TARGETED GENE ANALYSIS from SCH Panels Target gene(s) must be specified: _____ LAB3617 <input type="checkbox"/> Targeted Gene Sequencing by NGS LAB3616 <input type="checkbox"/> Targeted Gene Deletion/Duplication by Array MOLECULAR FAMILY FOLLOW-UP STUDY** **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>. LAB1915 <input type="checkbox"/> 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	Test code	BIOCHEMICAL GENETICS MOLECULAR ANALYSIS
LAB1808	<input type="checkbox"/> 22q11.2 Deletion/Duplication by MLPA (22q11.2 DS, DiGeorge, VCFS)	LAB3912	<input type="checkbox"/> Galactosemia (GALT) Sequencing
LAB1847	<input type="checkbox"/> Fragile X DNA (FMR1)	LAB1877	<input type="checkbox"/> MCAD (ACADM) Sequencing
LAB1894	<input type="checkbox"/> Prader-Willi/Angelman Methylation & CNV Analysis	LAB3941	<input type="checkbox"/> Ornithine Transcarbamylase (OTC) Deficiency Sequencing
LAB1912	<input type="checkbox"/> Spinal Muscular Atrophy <u>Diagnostic</u> (SMN1 & SMN2 Copy Number)	LAB1892	<input type="checkbox"/> Pompe (GAA) Sequencing
LAB1911	<input type="checkbox"/> Spinal Muscular Atrophy <u>Carrier</u> Test (SMN1 copy number)	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		

Test code	CYTOGENETIC ANALYSIS		
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)		
			<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> <p>LAB3622 <input type="checkbox"/> Family Study Karyotype</p> <p>LAB3621 <input type="checkbox"/> Family Study FISH</p> <p>LAB3623 <input type="checkbox"/> Family Study Chromosomal SNP Microarray</p> <p>LAB3616 <input type="checkbox"/> Targeted Gene Deletion/Duplication by Array</p> <p>LAB3682 <input type="checkbox"/> Proband Control specimen for:</p> <p>Family Member Name (Required): _____</p> <p>Relationship to Family Member (Required): _____</p> <p>Check test that will be performed <u>on family member</u>:</p> <p><input type="checkbox"/> Family Study Karyotype</p> <p><input type="checkbox"/> Family Study FISH</p> <p><input type="checkbox"/> Family Study Chromosomal SNP Microarray</p> <p><input type="checkbox"/> Targeted Gene Deletion/Duplication by Array</p>

** 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): _____

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