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 ☐ Saliva (OrageneDx OGD-575/675 only) ☐ Fresh Tissue
☐ Cord Blood Tissue source (Exact Anatomical Site): _____
☐ Extracted gDNA from blood
☐ EDTA ☐ 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 |
|---|---|
| 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 Panels** |
| LAB3799 | ☐ Autoimmune Lymphoproliferative Syndrome (ALPS) Panel |
| LAB3800 | ☐ Familial Hemophagocytic Lymphohistiocytosis (FHLH) Panel |
| LAB3904 | ☐ Primary Ciliary Dyskinesia (PCD) Panel |
| LAB3798 | ☐ Severe Combined Immunodeficiency (SCID) Panel |
| LAB3801 | ☐ Very Early Onset Inflammatory Bowel Disease (VEO-IBD) Panel |
| LAB3797 | ☐ ImmuneSeq Inborn Errors of Immunity 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 _____ |

Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

**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 (GALT) Sequencing |
| LAB1877 | ☐ MCAD (ACADM) Sequencing |
| LAB3941 | ☐ Ornithine Transcarbamylase (OTC) Deficiency 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

Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

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