Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Miscellaneous Specialty Testing

Department of Laboratories
4800 Sand Point Way NE OC.8.720
Seattle, WA 98105 (206) 987-2102
http://seattlechildrenslab.testcatalog.org

FAILURE TO COMPLETE MAY DELAY RESULTS

Patient's Last Name	First	Middle	Birth date (required)	Sex

Outside Patient Number	Outside Specimen Number	Send Report To:
Ordering Provider		Address:
Phone Number	DIAGNOSIS / ICD CODE:	Phone / Fax:

SPECIMEN INFORMATION: Date collected: / / ☐ Whole Blood ☐ Plasma ☐ Other: _____

Time collected: _____ am / pm ☐ Serum ☐ Urine _____

BIOCHEMICAL GENETICS

- ☐ **Acylcarnitine Profile, Blood**
- ☐ **Alpha Aminoadipic Semialdehyde (AASA)**
- ☐ **Amino Acids, Quantitative Plasma**
- ☐ **Biotinidase**
- ☐ **Carnitine, Plasma**
- ☐ **Galactose-1-Phosphate**
- ☐ **Galactose-1-PUT, Quantitative**
- ☐ **Glucose-6-PD Screen**
- ☐ **Homocysteine, Plasma**
- ☐ **Maple Syrup Urine Disease** (Leucine, Isoleucine, Valine, Alloisoleucine)
- ☐ **Organic Acids, Urine**
- ☐ **Phenylalanine / Tyrosine, Quantitative**
- ☐ **Succinylacetone Screen, Urine**
- ☐ **Succinylacetone, Quantitative Urine**
- ☐ **Very Long Chain Fatty Acids**

THERAPEUTIC DRUG MONITORING

- ☐ **Cephalexin (Keflex)**
- ☐ **Cyclosporin A** **Date/Time of last dose:** _____
- ☐ **Gabapentin (Neurontin)**
- ☐ **Ibuprofen (Advil, Motrin, etc.)** IBUPROFEN, IBUPROF P2, IBUPROF 4
  Collection times: _____ _____ _____ _____
- ☐ **Lamictal (Lamotrigine)**
- ☐ **Levetiracetam (Keppra)**
- ☐ **Methotrexate** **Date/Time of last dose:** _____
- ☐ **NTBC (Orfadin)**
- ☐ **Oxcarbazepine (Trileptal)**
- ☐ **Posaconazole**
- ☐ **Sirolimus (Rapamune)**
- ☐ **Tacrolimus** **Date/Time of last dose:** _____
- ☐ **Topiramate (Topamax)**
- ☐ **Voriconazole**
- ☐ **Zonisamide (Zonegran)**

MISCELLANEOUS

- ☐ **Beta-Hydroxybutyrate**
- ☐ **Calcium, Ionized**
- ☐ **Lactic Acid** (Indicate Venous or Arterial)
- ☐ **Rapid Resp Pertussis by PCR Qual**
- ☐ **CSF meningitis/encephalitis PCR Qual Panel**
- ☐ **Pyruvate*** requires special processing
- ☐ **Rotavirus, Stool**
- ☐ **Sickle Cell Screen***
- ☐ **VMA / HVA, Total Serum** (Vanillylmandelic acid, Homovanillic acid)

OTHER

_____

_____

_____

_____

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 (206) 987-2102.

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Ship to: LABORATORY
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SEATTLE, WA 98105