CENTER FOR HUMAN GENETICS LABORATORY

University Hospitals Laboratory Services Foundation
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www.uhhospitals.org/cleveland/services/genetics/laboratory

University Hospitals

Molecular Genetics Requisition

PATIENT INFORMATION (Label)

Name (Last, First)_____ Phone (H) (___)_____ DOB ____/____/_____
Address_____ (W) (___)_____ SS# ____-____-_____
City/State/Zip_____ **Sex:** □ **Male** □ **Female**
Referring Institution_____ **MRN**_____

Sample: □ Peripheral Blood □ Cord Blood □ CVS □ Amniotic Fluid _____cc's Gest Age_____
□ DNA □ Products of Conception (specify)_____ □ Tissue (specify)_____ □ Other (specify)_____
Date/Time of specimen collection:_____ Person Collecting_____ Location (institution): _____
Ethnicity: □ Caucasian □ African American □ Ashkenazi Jewish □ Hispanic □ Asian □ Native American□ Other _____

REFERRING PHYSICIAN/PROVIDER

Name_____ Signature_____
Phone:_____ Fax:_____ Pager:_____
BILLING INFORMATION □ Bill Referring Institution Results also sent to_____
□ *Bill Insurance Preauthorization #_____**NOTE: Most Genetic Tests require Preauthorization**
*(Attach Full Patient Demographics and Copy of Insurance card; Medicare - most genetic tests require a current date signed ABN)

INDICATIONS FOR TESTING / ICD-code: (Required) □ **Symptomatic** □ **Non-symptomatic** □ **Patient/couple pregnant**

TESTS REQUESTED

^ = send-out tests

Carrier Screening Tests (requires Purple EDTA tube)

___ Carrier Screening Panel
Panel includes the following, or mark off the individual tests
___Cystic Fibrosis Screening Panel (60 Mutations)
___Fragile X Syndrome PCR Analysis
(includes reflex to Methylation status for positive cases)
___Spinal Muscular Atrophy Exon 7 Copy Number Analysis

Single Gene/NGS Testing (requires Purple EDTA tube)

___ Cystic Fibrosis Gene Sequencing CFTR
___ Fumarate Hydratase (FH) Gene Sequencing
___ Pyruvate Carboxylase (PC) Gene Sequencing
___ Pyruvate Dehydrogenase Complex (PDC) panel
Performed sequentially in the following order, or individually
__ PDHA1 Gene Sequencing
__ PDHB Gene Sequencing
__ PDHX Gene Sequencing
__ DLAT Gene Sequencing
__ DLD Gene Sequencing
___ PDC NGS Panel (23 gene panel)

Targeted Molecular Tests (requires Purple EDTA tube)

___ Thrombosis Panel
Panel includes the following, or mark off the individual tests
__ Factor V Leiden, R506Q mutation
__ Reflex to Factor V HR2 Haplotype for positive R506Q
__ Prothrombin (Factor II) mutation, G20210A mutation

___Fragile X Syndrome PCR Analysis
___ Hereditary Hemochromatosis (H63D and C282Y)
___ Prader-Willi/Angelman Syndrome Methylation Analysis
___ Uniparental Disomy (chr. 6, 7, 14, or 15) chr# _____
- requires sample from at least one parent, preferably both
___ Y Deletion Analysis
___ MYBPC3 Amish Specific Mutation Analysis
___ SPG21 Amish Specific Mutation Analysis
___ PCCB Amish Specific Mutation Analysis
___ Known Familial Mutation Testing, Gene_____
Familial Mutation(s)_____
___ DNA Extract and Store:_____
___ Other Molecular Test _____

PRNP Gene Analysis: Please Call 216-368-0587
All Prion Disease testing MUST be submitted through the National Prion Disease Pathology Surveillance Center

Commonly Ordered Cytogenetics Tests

(For additional cytogenetics tests, please see Cytogenetics requisition)

___ Chromosomal Microarray (CMA), SNP (Green NaHep Tube)
___ Chromosome Analysis, High Resolution (Green NaHep Tube)
___ FISH analysis (Green NaHep Tube) _____