COLLAGEN DIAGNOSTIC LABORATORY

UW MEDICINE CENTER FOR PRECISION DIAGNOSTICS

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LABORATORY TEST REQUISITION FORM

PATIENT INFORMATION

NAME:
DOB:
SEX: ☐ MALE ☐ FEMALE
YOUR PATIENT ID#:
ADDRESS:
CITY: STATE: ZIP:
PHONE:

SAMPLE TYPE:

- ☐ Blood **(PREFERRED)** 5-7cc, purple top EDTA
- ☐ DNA (minimum 5μg)
- ☐ Saliva
- ☐ Amniocytes (2 T25-flasks, cultured)
- ☐ CVS Cells (2 T-25 flasks, cultured)
- ☐ Cultured fibroblasts
- ☐ Stored cells (CDL Repository)

REPORTING RESULTS

REFERRING PHYSICIAN (REQUIRED):
NAME:
NPI #:
PHYSICIAN SPECIALTY:
GENETIC COUNSELOR:
INSTITUTION:
ADDRESS:
CITY: STATE: ZIP:
COUNTRY:
PHONE:
FAX:
EMAIL:

REFERRING LAB:
SEND OUT COORDINATOR:
ADDRESS:
CITY: STATE: ZIP:
COUNTRY:
PHONE:
FAX:

At CDL, we are committed to excellence in health care, biomedical education and research. To this end we may use submitted clinical information and remaining specimens to better understand disease mechanism, to improve laboratory testing and for educational purposes. De-identified data from tested individuals may be submitted to clinical genetic data registries and/or for publication. Individuals may refuse to allow CDL to use their information and specimen by signing below. A description of this testing policy and research approach is available at *www.uwcdl.org*

OPT OUT SIGNATURE _____ ***DATE*** _____

CLINICAL INFORMATION – PLEASE ATTACH CLINIC NOTE

SUSPECTED DIAGNOSIS:

☐ Osteogenesis Imperfecta ☐ Ehlers-Danlos Syndrome ☐ Marfan Syndrome ☐ Loeys-Dietz Syndrome
☐ Familial Aneurysm Syndrome ☐ Other:

CLINICAL DESCRIPTION – PLEASE ATTACH CLINIC NOTE:

☐ Blue sclerae ☐ Hearing Loss ☐ High arched palate ☐ Lens dislocation ☐ Dentinogenesis Imperfecta
☐ Translucent skin ☐ Easy bruising ☐ Atrophic scarring ☐ Bifid Uvula ☐ Dural ectasia ☐ Scoliosis
☐ Bone deformity ☐ Short Stature ☐ Joint hypermobility ☐ Joint dislocations ☐ Congenital contractures

☐ Fractures (age and location):
☐ Vascular Event: dissection, aneurysm, rupture (age and location):

☐ Other findings/history:

☐ Positive family history (please include pedigree)

Special Instructions and Additional Information (if prenatal, include EDC):

TEST REQUESTED (*See website for current costs and CPT codes)*

☐ **Known Mutation/Variant Testing** (*Please provide copy of report if testing done at another laboratory)*

Name of Relative (Proband): CDL#:

Relationship to Proband: Gene: Mutation/Variant:

	Sequencing	Deletion/Duplication	Seq reflex to Del/Dup
Osteogenesis Imperfecta (OI) and genetic bone disorders			
Autosomal Dominant OI Panel (*COL1A1, COL1A2, IFITM5)*	☐	☐	☐
OI and Genetic Bone Disorders Panel	☐	☐	☐
(ALPL, B3GAT3, B4GALT7, BMP1, COL1A1, COL1A2, CREB3L1, CRTAP, FKBP10, GORAB, IFITM5, LRP5, MBTPS2, NBAS, P3H1, P4HB, PLOD2, PLOD3, PLS3, PPIB, SEC24D, SERPINF1, SERPINH1, SP7, SPARC, TAPT1, TMEM38B, TNFRSF11B, WNT1, XYLT2)			
Individual Gene(s):			
COL1A1 and *COL1A2*	☐	☐	☐
IFITM5	☐	☐	☐
Caffey Disease (*COL1A1* c.3040C>T)	☐		
Hypophosphatasia (*ALPL*)	☐	☐	☐
X-Linked Osteoporosis (*PLS3*)	☐	☐	☐
Osteopetrosis Panel	☐		
(AMER1, CA2, CLCN7, CTSK, FAM20C, FERMT3, LEMD3, LRP5, OSTM1, PLEKHM1, SNX10, TCIRG1, TNFRSF11A, TNFSF11)			
Ehlers-Danlos Syndromes (EDS)			
Comprehensive EDS Panel (*COL5A1, COL5A2, COL3A1, FLNA, PLOD1, COL1A1, COL1A2, ADAMTS2, C1S, C1R, ATP7A, CHST14, FKPBP14, SLC39A13)*	☐	☐	☐
Classical and Vascular EDS Panel (*COL5A1, COL5A2, COL3A1*)	☐	☐	☐
Classical EDS, types I, II (*COL5A1* and *COL5A2*)	☐	☐	☐
Vascular EDS, type IV (*COL3A1*)	☐	☐	☐
Ocular-scoliotic EDS, type VI (*PLOD1*)	☐	☐	☐
Arthrochalasia, type VIIA/B (Exon 6 *COL1A1*/*COL1A2*)	☐	☐	☐
Dermatosparaxis, type VIIC (*ADAMTS2*)	☐	☐	☐
Periodontal EDS, type VIII (*C1S* and *C1R*)	☐		
FKBP14-related EDS	☐	☐	☐
Complex EDS-like Disorders	☐	☐	☐
(B3GALT6, B4GALT7, B3GAT3, CHST14, CHST3, XYLT1)			
Vascular Genetic Disorders			
Arterial Aneurysm Panel	☐	☐	☐
(ACTA2, BGN, CBS, COL3A1, FBN1, FBN2, FOXE3, LOX, MAT2, MFAP5, MYH11, MYLK, PLOD3, PRKG1, SKI, SLC2A10, SMAD2, SMAD3, SMAD4, TGFB2, TGFB3, TGFBR1, TGFBR2)			
Marfan Syndrome and Loeys-Dietz Syndrome Panel (*FBN1, SMAD2, SMAD3, SMAD4, TGFB2, TGFB3, TGFBR1, TGFBR2)*	☐	☐	☐
Marfan Syndrome (*FBN1*)	☐	☐	☐
COL4A1 and *COL4A2* Related Disorders (*COL4A1* and *COL4A2*)	☐	☐	☐
Cutis Laxa Panel	☐	☐	☐
(ALDH18A1, ATP6V0A2, ATP6V1A, ATP6V1E1, ATP7A, EFEMP2, ELN, FBLN5, GORAB, LTBP4, PYCR1, RIN2, SLC2A10)			
Ectopia Lentis Panel	☐		
(ADAMTS10, ADAMTS17, ADAMTSL4, CBS, FBN1)			
Alport Syndrome			
Alport Syndrome Panel *(COL4A3, COL4A4, COL4A5*)	☐	☐	☐
X-Linked Alport Syndrome (*COL4A5*)	☐	☐	☐
Stickler Syndrome			
Stickler Panel *(COL2A1, COL9A1, COL9A2, COL9A3, COL11A1, COL11A2*)	☐	☐	☐
Maternal Cell Contamination Studies	☐		

COLLAGEN DIAGNOSTIC LABORATORY

BILLING INFORMATION

Requested laboratory testing will be initiated only AFTER accurate billing information is provided.
Canadian samples: Providers must acquire approval of all tests, including reflex testing, before submitting samples.

☐ **BILL INSTITUTION: INSTITUTIONAL BILLING**

Institution Name:
Tax ID Number: PO#:
City: State: ZIP:
Phone: Fax:
Send Result Report: ☐

☐ **BILL PATIENT: SELF-PAY or INTERNATIONAL SAMPLES**

☐ Check *(payable to UW Physicians)* or Money Order Amount (USD):
☐ Credit Card: Please contact CDL billing at (206) 221-1274 to provide credit card information over a secure line.
☐ Electronic Funds Transfer (EFT) (See website for details) EFT Amount: USD

☐ **BILL INSURANCE: PATIENT INSURANCE**

Preauthorization is required for all insurance billing

☐ Do insurance preauthorization PROCEED if approved; include PreAuth Form
☐ Do insurance preauthorization CONTACT PROVIDER before proceeding; include PreAuth Form
☐ Preauthorization already obtained; PreAuth approval #_____

Please attach a copy of card for all insurance billing

Name on Policy:
Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other (please specify):
Cardholder DOB: Dates of Coverage:
Patient Policy ID#:
Group Name: Group #:
Insurance Co. Name:
Claims Billing Address:

Patient Insurance Billing Consent:

I authorize the CDL to release to my designated insurance carrier, health plan, or third party administrator the information on this form and any other information provided by my health care provider necessary for reimbursement. I assign and authorize insurance payments to the CDL. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity, or otherwise. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State or Federal law. A duplicate or faxed copy of this authorization is considered the same as the original document.

Patient Signature: **Date:**

☐ **BILL MEDICAID:** For Medicaid Billing, the following is required: Medicaid claims address, copy of card, and Letter of Medical Necessity from referring physician.

☐ **BILL MEDICARE:** A completed Advance Beneficiary Notice (ABN) is required for Medicare patients (see website).

SHIP SAMPLE OVERNIGHT TO:
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Lab H-561, Health Science Bldg.
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Seattle, WA 98195