UW MEDICINE CENTER for PRECISION DIAGNOSTICS
NORTHWEST CLINICAL GENOMICS LABORATORY
1959 NE PACIFIC AVE., LAB H-561, SEATTLE, WA 98195
PHONE: 206.543-0459 or 206.616.4115
www.uwcpdx.org/ncgl email: cpdx@uw.edu

PATIENT INFORMATION

Name:
Address:
City: State: ZIP:
Phone (home):
Phone (other):
Date of birth: MRN:
Gender: ☐ Male ☐ Female ☐ Unknown
Ethnic background (select all that apply):
☐ African American ☐ Hispanic
☐ Caucasian (White) ☐ Asian
☐ Ashkenazi Jewish ☐ Native American
☐ Other:

ORDERING PHYSICIAN

Name:
Organization:
Address:
City: State: ZIP:
Phone: FAX:
Email:

OTHER REPORT RECIPIENT

Name:
Address:
City: State: ZIP:
Phone: FAX:
Email:

SAMPLE INFORMATION

Date of collection: Collected by:
Specimen type: Whole blood (lavender top - EDTA tube) Extracted DNA Other:

FAMILIAL (BIOLOGICAL) SAMPLES

Mother:		Father:	
Date of birth:	Date of collection:	Date of birth:	Date of collection:
☐ Whole blood	☐ Extracted DNA	☐ Whole blood	☐ Extracted DNA
☐ Asymptomatic	☐ Symptomatic	☐ Asymptomatic	☐ Symptomatic
Other:		Other:	
Date of birth:	Date of collection:	Date of birth:	Date of collection:
☐ Whole blood	☐ Extracted DNA	☐ Whole blood	☐ Extracted DNA
☐ Asymptomatic	☐ Symptomatic	☐ Asymptomatic	☐ Symptomatic

TEST TO BE PERFORMED

☐ MOVEMENT Disorder Panel
☐ NEURODEGENERATIVE Disorder Panel
☐ NEUROMUSCULAR Disorder Panel
☐ Comprehensive Cardiomyopathy/Arrythmia Panel
☐ Known Mutation Testing (Sanger Sequencing)
Gene _____ Variant _____

☐ Cardiomyopathy Panel
☐ Cardiac Arrhythmia Panel
☐ Exome Panel on Demand (≤ 200 genes)
☐ "Mini" Exome Panel on Demand (≤10 genes)
Use web tool at https://ncgl.uwcpdx.org/panel-on-demand/ to add genes to a custom panel
RECORD 5 CHARACTER CODE here: _____

Internal Use Only:
☐ Test requisition completed for each sample
☐ Clinical information & additional description
☐
Medical records, including previous genetic test results
indicate: ☐ Microarray ☐ Karyotype ☐ Single gene
Detailed family history and pedigree (attached)

Receipt date/time: _____ , _____ AM / PM Sample condition: ☐ Acceptable ☐ Request resample

REQUISITION FORM

Patient name: _____ Date of birth: _____ (MM/DD/YYYY)

CLINICAL INFORMATION

Indication for Study and Pertinent Clinical Information (provide any suspected clinical diagnoses or state if unaffected):

_____
_____
_____

Previous Genetic Testing: ☐ **No** ☐ **Yes - Provide results:** _____

Suspected Mode of Inheritance:	**Dominant**	**Recessive**	**X-linked**	**De novo**	**Mitochondrial**
	☐	☐	☐	☐	☐

ICD-9 Code(s): _____

EXOME PANEL TESTING DESCRIPTION

The genes in each panel are sequenced as part of the sequence of an entire exome. For each gene in the designated panel all coding nucleotides are sequenced in at least 20 different fragments (20x coverage) or the fragment is sequenced by Sanger methodology. We have chosen this approach to sequence all known candidate genes. If no mutations are identified, then examination of the entire exome is available by re-analysis of the sequence (request Reflex to Exome Sequencing) without additional laboratory work.

During panel test analysis and interpretation, variants detected in other genes, even those in those deemed "medically actionable" by the ACMG guidelines, are not examined but can be provided when *Reflex to Exome Sequencing* is requested. The Reflex study is completed on request with appropriate consent from the patient/family. Clinicians are encouraged to translate these limitations of panel testing by exome to the patient and to contact the NCGL laboratory directors with any related questions.

RESEARCH POLICIES & OPPORTUNITIES

Blood or other samples sent to the Northwest Clinical Genomics Laboratory (NCGL) may be used by UW Medicine, by medical organizations affiliated with UW Medicine, or by educational or business organizations approved by UW Medicine, for research, education and other activities that support UW Medicine's mission, without your/your child's specific consent. Other types of research performed in association with the NCGL require that we obtain consent from the patient (below).

PATIENTS – Please check off and initial below whether we can contact you to let you know about research studies requiring consent in which you/your child may be able to participate. These research studies may include: 1) a request for additional clinical records about your condition, 2) studies to find new causes for your condition, and 3) studies to evaluate newly developed treatments for your condition.

Patient Name: _____ Date of Birth: _____ / _____ / _____ (MM/DD/YYYY)

Please check one: ☐ Yes, you can contact me _____ (Patient/Guardian initials)

If yes, please provide your contact information on the first page of the requisition form.

☐ No, please do not contact me _____ (Patient/Guardian initials)

SAMPLE & SHIPPING REQUIREMENTS

Blood samples should be collected in lavender top (potassium EDTA) tubes: 7mL (3-5mL for infants). All samples must be labeled with two unique identifiers: 1) the patient's full name and 2) date of birth. If possible please include the patient's medical record number. Please contact the laboratory for more details and blood tube kits.

Sample (with forms) should be shipped overnight at room temperature to:

Center for Precision Diagnostics
Northwest Clinical Genomics Laboratory
1959 NE Pacific St., HSC H-561
Seattle, WA 98195

For more detailed information about shipping requirements and procedures, please contact the lab at 206-543-0459.

REQUISITION FORM

Patient name: _____ Date of birth: _____ (MM/DD/YYYY)

BILLING INFORMATION and AUTHORIZATION

☐ **Do insurance preauthorization PROCEED if approved** **include preauth form** ☐ **PROCEED to testing without preauthorization (add billing below)**

☐ **Do insurance preauth CONTACT PROVIDER before proceeding** **include preauth form**

1. INSTITUTION			
Institution:	Tax ID #:	PO#:	
Claims Billing Address:	City:	State:	Zip:
Billing Contact Name:	Phone:	FAX:	

2. INSURANCE			
Policyholder Name:	Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other (specify):		
Policyholder DOB:	Dates of Coverage:		
Patient Policy ID#:	Group Name:	Group #:	
Insurance Company Name:			
Claims Billing Address:	City:	State:	Zip:
Phone:	FAX:		
ICD9 Diagnosis Code(s):			

3. SELF-PAY				
Payment Method: ☐ Cashier Check / Money Order (Payable to *UW Physicians*)				
☐ Visa	☐ MasterCard	☐ AmEX	☐ Discover	
Amount (USD): (Amount authorized to be charged)				
Card #:	Expiration Date:	CVV#:		
Name of Cardholder:				
Billing Address:	City:	State:	Zip:	
☐ Electronic Funds Transfer (EFT) (See website for details)				
EFT Amount (USD):				

4. MEDICAID
For Medicaid billing, the following is <u>required</u>:
1. A pre-authorization letter from Medicaid, with the effective dates of coverage
2. Medicaid claims address
3. Copy of Medicaid card
4. Letter of necessity from referring physician