UW MEDICINE CENTER FOR PRECISION DIAGNOSTICS
NORTHWEST CLINICAL GENOMICS LABORATORY
1959 NE PACIFIC AVE., LAB H-561, SEATTLE, WA 98195
PHONE: 206-543-0459; 206-221-2140
www.uwcpdx.org 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

☐ Exome Sequencing and Interpretation

☐ Trio-Exome Sequencing and Interpretation
Trio Proband
Trio Mother
Trio Father
Other family member for support of proband testing
Relationship to Proband:
Proband Name:

☐ Reflex Exome Sequencing - (only after completion of exome "panel"

☐ Genome Sequencing and Interpretation

☐ Trio-Genome Sequencing and Interpretation
Trio Proband
Trio Mother
Trio Father
Other family member for support of proband testing
Relationship to Proband:
Proband Name:

Internal Use Only:

☐ Test requisition completed for each sample
☐ Signed consent form for each individual
☐ 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**

Medical History: For any section marked "Abnormal" please provide additional information

ICD-9 Code(s): _____

Perinatal / Prenatal History:
☐ Abnormal ☐ Normal ☐ Unknown

In Utero Abnormalities of Proband:
☐ Abnormal ☐ Normal ☐ Unknown

Growth and Build:
☐ Abnormal ☐ Normal ☐ Unknown

Head and Neck:
☐ Abnormal ☐ Normal ☐ Unknown

Voice:
☐ Abnormal ☐ Normal ☐ Unknown

Chest and Thorax:
☐ Abnormal ☐ Normal ☐ Unknown

Cardiovascular:
☐ Abnormal ☐ Normal ☐ Unknown

Respiratory:
☐ Abnormal ☐ Normal ☐ Unknown

Abdomen:
☐ Abnormal ☐ Normal ☐ Unknown

Genital System:
☐ Abnormal ☐ Normal ☐ Unknown

Urinary System:
☐ Abnormal ☐ Normal ☐ Unknown

Skeletal:
☐ Abnormal ☐ Normal ☐ Unknown

Muscle, Soft Tissue:
☐ Abnormal ☐ Normal ☐ Unknown

Neurologic:
☐ Abnormal ☐ Normal ☐ Unknown

Skin, Nails, Hair:
☐ Abnormal ☐ Normal ☐ Unknown

Immunology:
☐ Abnormal ☐ Normal ☐ Unknown

Endocrine System:
☐ Abnormal ☐ Normal ☐ Unknown

Hematology:
☐ Abnormal ☐ Normal ☐ Unknown

Metabolic:
☐ Abnormal ☐ Normal ☐ Unknown

Neoplasia:
☐ Abnormal ☐ Normal ☐ Unknown

Abnormal Laboratory Results:
☐ Abnormal ☐ Normal ☐ Unknown

Please list any genes for which you are requesting specific analysis or note any special requests here. (Please note: The lab will also generate a list of genes and variants based on clinical features and indication of study unless directed otherwise):

_____

_____

REQUISITION FORM

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

BILLING INFORMATION and AUTHORIZATION

☐ **Do insurance preauthorization PROCEED if approved** **include preauth form**

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

☐ **PROCEED to testing without preauthorization (add Billing below)**

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 (attach to requisition form)
2. Medicaid claims address
3. Copy of Medicaid card (attach to requisition form)
4. Letter of necessity from referring physician (attach to requisition form)

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.

Samples must be accompanied by a requisition form and signed consent forms below.
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 206-685-7897.