

UW MEDICINE CENTER for PRECISION DIAGNOSTICS

NORTHWEST CLINICAL GENOMICS LABORATORY

1959 NE PACIFIC AVE., LAB H-561, SEATTLE, WA 98195 PHONE:

PHONE: 206-543-0459; FAX: 206-616-1899 www.uwcpdx.org

EXOME PANEL TEST REQUISITION

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	
Cardiac Arrhythmia Panel Cardiomyopathy Panel Comprehensive Cardiac Arrhythmia/Cardiomyopathy Panel Retinal Dystrophy Panel	Single Gene Sequencing* Micro Exome Panel on Demand (2-10 genes*) Mega Exome Panel on Demand (11-100 genes*) Super Exome Panel on Demand (101-200 genes*) Hyper Exome Panel on Demand (201-500 genes*)
Known Mutation Testing (Sanger Sequencing) Gene Variant	*Use web tool at https://ncgl.uwcpdx.org/panel-on-demand/ to add genes to a custom panel
Proband (if tested at NCGL): Relationship to Proband:	RECORD 5 CHARACTER CODE here:

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):

Please include clinic note if available.

Previous Genetic Testing: No Yes - Provide results: _____

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

ICD-10 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)

BILLING INFORMATION AND AUTHORIZATION

Insurance Billing Pre-Authorization (not offered for tests <\$500)

Do insurance preauthorization; PROCEED if approved (PREAUTH FORM and sample required)

Do insurance preauthorization; CONTACT PROVIDER before proceeding (PREAUTH FORM and sample required)

PROCEED to testing without preauthorization (add billing information below)

1. BILL INSTITUTION

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

2. BILL INSURANCE (SEE PRE-AUTH ABOVE)

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 <i>UW Physicians</i>)				
	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.	Medicaid claims address
2.	Copy of Medicaid card (attach to requisition form)
3.	Letter of medical necessity from referring physician; impact on future care (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 test kits.

Samples must be accompanied by a requisition form and signed consent forms (when applicable).

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.