THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

OU PHYSICIANS &
OU CHILDREN'S PHYSICIANS

GENETICS LABORATORY
SEQUENCING REQUISITION FORM

PLEASE COMPLETE ALL FORMS AND
SEND WITH PATIENT SAMPLE

Ship To: O'Donoghue Research Bldg
1122 NE 13 Street, Suite 1400
Oklahoma City, OK 73104
Phone: 405-271-3589
Fax: 405-271-7117
After hours phone: 405-496-9514
www.genetics.ouhsc.edu

Courier service in OKC metro area call
Rapid Transit 793-1122 for specimen pickup

REFERRING PHYSICIAN/FACILITY

Physician Name _____

NPI_____

Phone(____)_____ Fax(___)_____

Genetic Counselor_____ Phone(__)_____

Laboratory/Institution_____

Address_____

City_____ State_____ Zip_____

Phone_(___)_____ Fax (____)_____

PATIENT INFORMATION

Patient Name (last,first,m.)_____

Parent Name (if pt is a minor)_____

DOB_____ SSN_____ MRN_____

Sex: □ Male □ Female □ Ambiguous □ Unknown □ Inpatient □ Outpatient

Ethnicity of patient (check all that apply)
□ African-American □ Asian □Caucasian/NW European □ E. Indian
□ Hispanic □ Jewish-Ashkenazi □ Jewish-Sephardic □ Native American
□ Native Hawaiian/Other Pacific Islander □ Other_____

Patient's Address_____

City_____ State_____ Zip _____

SPECIMEN INFORMATION (Please refer to the third page for collection requirements.)

□ **Peripheral Blood** □ **Amniotic Fluid/Cultured Amniocytes** □ **Isolated DNA**

Date Specimen Collected_____ Conditions/Symptoms_____

TEST INFORMATION (Please Mark the Test(s) You are Requesting)

□ Angelman syndrome	*UBE3A*	□ MCAD	*ACADM*
□ Bernard-Soulier syndrome	*BP1Bb*	□ Malignant Melanoma	*CDKN2A*
□ Beta-thalessemia	*HBB*	□ Pancreatic Cancer	*PALB2*
□ Biotinidase deficiency	*BTD*	□ Rett syndrome	*MECP2*
□ CHARGE syndrome	*CHD7*	□ SCAD	*ACADS*
□ Cockayne syndrome-A	*ERCC8*	□ Sotos syndrome	*NSD1*
□ Costello syndrome	*HRAS*	□ TMD (Down's syndrome)	*GATA1*
□ Cystic Fibrosis	*CFTR*	□ VLCAD	*ACADVL*
□ Ehlers-Danlos syndrome	*CHST14*	□ Von Hippel-Lindau syndrome	*VHL*
□ Familial Hypercholesterolemia	*LDLR*	□ Williams syndrome	*ELN*
□ Galactosemia	*GALT*	□ Wilsons disease	*ATP7B*
□ Glutaric Acidemia Type 1	*GCDH*	□ Site Specific/Familial Mutation	_____
□ Isovaleric Acidemia	*IVD*	(please include copy of lab report stating mutation sites)	
□ Hamartoma Tumor syndrome	*PTEN*		
□ Hereditary Papillary Renal Carcinoma	*MET*		
□ HLRCC	*FH*		
□ Kabuki syndrome	*MLL2*		
□ Li-Fraumeni syndrome	*TP53*		
□ Marfan syndrome	*FBN1*		
□ Marinesco-Sjogren syndrome	*SIL1*		

ADDITIONAL REPORT

Physician/Facility_____

Phone_(___)_____ Fax_(___)_____

Address_____

_____

GENETICS LABORATORY USE ONLY

Laboratory Number_____

Date/Time/Location of Pick-Up or Delivery_____

Initials_____ Check-in_____

Previous Lab Number_____ 1/23/2017

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Patient Name Last_____ First_____ MI_____

TEST INFORMATION CONTINUED

Tests can be performed sequentially or individually.
Genes are listed according to their prevalence in a disorder.

Adams-Oliver syndrome

☐ *ARHGAP31* ☐ *DLL4*
☐ *DOCK6* ☐ *NOTCH1*
☐ *RBPJ*
☐ *EOGT*

Bartter syndrome

☐ Type 1 *SLC12A1*
☐ Type 2 *KCNJ1*

Cardiofaciocutaneous syndrome

☐ *BRAF*
☐ *MAP2K1*
☐ *MAP2K2*
☐ *KRAS*
☐ *SHOC2*

Early Childhood Hearing Loss

☐ Connexin 26 *GJB2*
☐ Connexin 30 *GJB6*

Hereditary Breast & Ovarian Cancer

☐ *BRCA1*
☐ *BRCA2*

Hereditary Multiple Osteochondromas

☐ Type 1 *EXT1*
☐ Type 2 *EXT2*

Hereditary & Idiopathic Chronic Pancreatitis panel

☐ *PRSS1*
☐ *CFTR*
☐ *SPINK1*
☐ *CTRC*

Hereditary Non-Polyposis Colon Cancer/Lynch syndrome

☐ *MSH2*
☐ *MLH1*
☐ *MSH6*
☐ *EPCAM*

Infantile Epilepsy

☐ *SCN1A*
☐ *SLC2A1*
☐ *CDKL5*
☐ *STXBP1*
☐ *KCNQ2*
☐ *KCNQ3*
☐ *SCN2A*

Liddle syndrome

☐ *SCNN1B*
☐ *SCNN1G*

MODY

☐ MODY2	*GCK*	☐ Seq	☐ Del/Dup
☐ MODY3	*HNF1A*	☐ Seq	☐ Del/Dup
☐ MODY1	*HNF4A*	☐ Seq	☐ Del/Dup
☐ MODY5	*HNF1B*	☐ Seq	☐ Del/Dup
☐ MODY4	*PDX1*	☐ Seq	☐ Del/Dup
☐ MODY6	*NEUROD1*	☐ Seq	☐ Del/Dup

Multiple Endocrine Neoplasia

☐ Multiple Endocrine Neoplasia 1 *MEN1*
☐ Multiple Endocrine Neoplasia 2 *RET*

Neurofibromatosis

☐ Neurofibromatosis 1 *NF1*
☐ Legius syndrome *SPRED1*
☐ Neurofibromatosis 2 *NF2*

Niemann-Pick disease type C

☐ *NPC1*
☐ *NPC2*

Noonan syndrome

☐ NS1 *PTPN11*
☐ NS3 *KRAS*
☐ NS4 *SOS1*
☐ NS5 *RAF1*
☐ NS7 *BRAF*
☐ NS6 *NRAS*

ADDITIONAL REPORT

Physician/Facility_____

Phone_(___)_____ Fax_(___)_____

Address_____

_____

GENETICS LABORATORY USE ONLY

Laboratory Number_____

Date/Time/Location of Pick-Up or Delivery_____

Initials_____ Check-in_____

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Patient Name Last_____ First_____ MI_____

TEST INFORMATION CONTINUED

Paraganglioma genes

☐ *SDHD*
☐ *SDHB*
☐ *SDHC*
☐ *SDHA*
☐ *SDHAF2*
☐ *MAX*

Polyposis of the colon

☐ *MUTYH Associated Polyposis*
☐ Familial Adenomatous Polyposis *APC*
☐ Juvenile Polyposis *BMPR1A*
☐ Juvenile Polyposis *SMAD4*

Renal Tubular Acidosis

☐ *CA2*
☐ *SLC4A1*
☐ *ATP6V0A4*
☐ *ATP6V1B1*
☐ *SLC4A4*

SPECIMEN REQUIREMENTS

Peripheral Blood
3-5 cc in large EDTA tube (purple top), mix well. Keep specimen at room temperature or cooler, do not freeze.

Amniotic Fluid/Cultured Amniocytes
5-10 cc in sterile centrifuge tubes. Keep specimen cool but do not freeze. DO NOT TRANSPORT SPECIMENS IN SYRINGES! Cultured amniocytes must be shipped in 2 T-25 flasks.

Isolated DNA please contact lab to obtain concentration and volumes that are required.

If shipping materials via Fedex/UPS packages can only be accepted Mon-Fri 9:00 AM to 5:00 PM. Our facilities are not accessible by delivery personnel on weekends or after hours.

ADDITIONAL REPORT

Physician/Facility_____

Phone_(___)_____ Fax_(___)_____

Address_____

_____

GENETICS LABORATORY USE ONLY

Laboratory Number_____

Date/Time/Location of Pick-Up or Delivery_____

Initials_____ Check-in_____

Previous Lab Number_____

GENETICS LABORATORY
BILLING INFORMATION FORM

PATIENT NAME LAST_____ FIRST_____ MI_____

YOU MUST CHOOSE ONE OF THE THREE BILLING OPTIONS LISTED BELOW.
PLEASE FORWARD ALL BILLING QUESTIONS TO DANIELLE OTIS AT DOTIS@OUHSC.EDU OR CALL 405-271-3589 OPT 4
AT THIS TIME WE DO NOT ACCEPT OUT OF STATE MEDICAID

PAYMENT OPTION 1-INSTITUTION

INSTITUTION NAME _____

BILLING ADDRESS_____

CITY, STATE, ZIP _____ CONTACT NAME_____

PHONE NUMBER_____ FAX NUMBER_____ CONTACT EMAIL ADDRESS _____

PAYMENT OPTION 2-SELF PAY (PAYMENT MUST BE SENT WITH SAMPLE)

☐ **CREDIT CARD** (CIRCLE ONE) AMEX DISCOVER VISA MASTERCARD AMOUNT TO CHARGE_____

VALID CARD # _____ EXP DATE_____

CVC CODE _____ CARDHOLDER PRINTED NAME_____

BILLING ADDRESS _____ CITY, STATE, ZIP_____

CARDHOLDER SIGNATURE _____

☐ **CHECK #** _____ AMOUNT ENCLOSED_____

PAYMENT OPTION 3-INSURANCE PROVIDE A LEGIBLE COPY OF THE FRONT & BACK OF INSURANCE CARD
Please Note: Currently Healthchoice, Humana Military (Tricare), and Medicare are NOT covering sequencing analysis.

PRIMARY INSURANCE POLICYHOLDER NAME _____ POLICYHOLDER DOB_____

PRIMARY POLICYHOLDER SS# _____ GENDER: M F EMPLOYER_____

RELATIONSHIP TO PATIENT_____ POLICY # _____

GROUP #_____ INSURANCE CO. NAME _____

PHONE _____ CLAIMS ADDRESS _____

CITY, STATE, ZIP_____

SECONDARY INSURANCE POLICYHOLDER NAME _____ POLICYHOLDER DOB_____

SECONDARY POLICYHOLDER SS# _____ GENDER: M F EMPLOYER_____

RELATIONSHIP TO PATIENT_____ POLICY # _____

GROUP #_____ INSURANCE CO. NAME _____

PHONE _____ CLAIMS ADDRESS _____

I CONSENT TO HAVE THE TEST(S) LISTED ON THE PREVIOUS PAGE PERFORMED. I AUTHORIZE THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY TO FURNISH ANY MEDICAL INFORMATION REQUESTED ON MYSELF, OR MY COVERED DEPENDENTS. IN CONSIDERATION OF SERVICES RENDERED, I TRANSFER AND ASSIGN ANY BENEFITS OF INSURANCE TO UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY. I UNDERSTAND I AM RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT IF THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY IS NOT A PARTICIPANT WITH MY HEALTH PLAN, AND MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME _____ SIGNATURE_____ DATE _____