THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

GENETICS LABORATORY
SINGLE GENE SEQUENCING REQUISITION FORM

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

PLEASE COMPLETE ALL FORMS AND
SEND WITH PATIENT SAMPLE

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

ORDERING PHYSICIAN/FACILITY

Physician Name _____

NPI_____

Phone(____)_____ Fax(___)_____

Genetic Counselor_____ Phone(__)_____

Facility_____

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** □ **Buccal Swab** □ **Isolated DNA** □ **Other_____**

Date Specimen Collected_____ Time Specimen Collected _____

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

☐ Angelman syndrome	*UBE3A*
☐ Biotinidase Deficiency	*BTD*
☐ Beta-thalessemia	*HBB*
☐ Biotinidase deficiency	*BTD*
☐ CHARGE syndrome	*CHD7*
☐ Costello syndrome	*HRAS*
☐ Cystic Fibrosis	*CFTR*
☐ Galactosemia	*GALT*
☐ Glutaric Acidemia Type 1	*GCDH*
☐ Isovaleric Acidemia	*IVD*
☐ Hamartoma Tumor syndrome	*PTEN*
☐ HLRCC	*FH*
☐ Legius syndrome	*SPRED1*
☐ Marfan syndrome	*FBN1*
☐ Marinesco Sjogren syndrome	*SIL1*
☐ MCAD	*ACADM*
☐ Neurofibromatosis 1	*NF1*
☐ Neurofibromatosis 2	*NF2*
☐ Pancreatic Cancer	*PALB2*
☐ Phenylketonura (PKU)	*PAH*
☐ Rett syndrome	*MECP2*
☐ SCAD	*ACADS*
☐ Sotos syndrome	*NSD1*
☐ Transient Myeloproliferative Disorder	*GATA-1*
☐ VLCAD	*ACADVL*
☐ Von Hippel-Lindau syndrome	*VHL*
☐ Wilsons disease	*ATP7B*
☐ Single Gene sequencing analysis	_____
☐ Site Specific/Familial Mutation (please include copy of lab report listing mutation sites)	_____
Deletion/Duplication analysis is available for ☐ each gene listed	

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_____

1/6/2020

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Patient Name Last_____ First_____ MI_____

DIAGNOSTIC INFORMATION

SEE PAGE 3 AND COMPLETE THE CLINICAL INFORMATION FORM FOR YOUR PATIENT.

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.

Buccal Swab
Please contact our lab and request a collection kit.

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

Other
Please contact the lab to discuss other accepted sample types.

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.

For pickup in the State of Oklahoma, contact Rapid Dispatch Services, 405-793-1122. If you have questions regarding specimen collection or pickup please contact the Genetics Lab staff by calling 405-271-3589.

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_____

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Genetics Laboratory

Patient/Proband Clinical Information Form

Last Name: _____First: _____ MI: ___ DOB: _____

Primary Indications for Testing

- ❑ Multiple Congenital Anomalies
- ☐ Developmental Delays
- ❑ Neurological/Muscular Disorder

Previous Testing

- ❑ Karyotype/FISH
- ❑ CMA
- ❑ Newborn Screen Result
- ❑ Other Results_____

Family History (provide pedigree)

- ❑ Consanguinity
- ❑ Family History of Genetic Disease/Disorder

Development & Cognition

- ❑ Autism Spectrum
- ❑ Fine Motor Delays
- ❑ Global Delay
- ❑ Gross Motor Delays
- ❑ Intellectual Delays
  - □ Mild
  - □ Moderate
  - □ Severe
- ❑ Learning Delays
- ❑ Speech Delay

Perinatal History

- ❑ IUGR / SGA

Growth

- ❑ Failure to thrive
- ❑ Macrocephaly
- ❑ Microcephaly
- ❑ Overgrowth/Tall
- ❑ Short stature
- ❑ Other:_____

Craniofacial Anomalies

- ❑ Cleft Lip
- ❑ Cleft Palate
- ❑ Craniosynostosis
- ❑ Dysmorphic Facies
- ❑ Ear Malformation
- ❑ Other:_____

Ear / Hearing Loss (HL)

- ❑ Conductive HL
- ❑ Microtia
- ❑ Sensorineural HL
- ❑ Other:_____

Eye Anomalies

- ❑ Aniridia
- ❑ Congenital Cataract
- ❑ Cortical Blindness/CVI
- ❑ Coloboma
- ❑ Glaucoma
- ❑ Optic Nerve Abnormality
- ❑ Ptosis
- ❑ Retinitis Pigmentosa
- ❑ Other:_____

Pulmonary

- ❑ Diaphragmatic Hernia
- ❑ TE Fistula
- ❑ Other:_____

Cardiac

- ❑ Arrhythmia
- ❑ ASD
- ❑ Cardiomyopathy
- ❑ Coarctation of aorta
- ❑ Dextrocardia
- ❑ Tetralogy of fallot
- ❑ Ventriculomegaly
- ❑ VSD
- ❑ Other:_____

GI

- ❑ Anal Atresia
- ❑ Chronic Obstruction
- ❑ Dysphagia
- ❑ Esophageal Atresia
- ❑ Gastroschisis
- ❑ Hirschsprung Disease
- ❑ Liver Disease
- ❑ Omphalocele
- ❑ Polysplenia
- ❑ Situs Inversus
- ❑ Other:_____

Genitourinary

- ❑ Ambiguous Genitals
- ❑ Cryptochidism
- ❑ Hydronephrosis
- ❑ Hypospadias
- ❑ Kidney Malformation
- ❑ Renal Agenesis
- ❑ Renal Tubulopathy
- ❑ Other:_____

Skeletal

- ❑ Arthrogryposis
- ❑ Club Foot/Feet
- ❑ Contractures
- ❑ Joint Hypermobility
- ❑ Kyphosis
- ❑ Limb Anomaly
- ❑ Osteopenia
- ❑ Pes Planus
- ❑ Polydactyly
- ❑ Scoliosis
- ❑ Skeletal Dysplasia
- ❑ Syndactyly
- ❑ Vertebral anomaly
- ❑ Other:_____

Endocrine

- ❑ Diabetes Insipidus
- ❑ Diabetes Mellitus
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Hyperparathyroidsim
- ❑ Hypoparathyroidism

Hematologic/Immuno

- ❑ Anemia
- ❑ Immunodeficient
- ❑ Neutropenia
- ❑ Pancytopenia
- ❑ Thrombocytopenia
- ❑ Other:_____

Neurological & Muscular

- ❑ Ataxia
- ❑ Brain Anomaly
- ❑ Cerebellar anomaly
- ❑ Chorea/Dystonia
- ❑ Encephalopathy
- ❑ Holoprosencephaly
- ❑ Hydrocephalus
- ❑ Hypertonia
- ❑ Hypotonia
- ❑ Lissencephaly
- ❑ Leukodystrophy
- ❑ Muscle Weakness/Atrophy
- ❑ Peripheral Neuropathy
- ❑ Vermis Hypoplasia
- ❑ Other:_____

Cancer/Tumors

- ❑ Tumor (describe)_____

_____

Age of Onset_____

Skin, Hair & Nails

- ❑ Abnormal Hair
- ❑ Abnormal Nails
- ❑ Hyperpigmentation (describe)_____
- ❑ Hypopigmentation (describe)_____
- ❑ Lipoma
- ❑ Other:_____

Metabolic Abnormalities

- ❑ Hyperammonemia
- ❑ Ketosis
- ❑ Lactic Acidosis
- ❑ Metabolic Acidemia
- ❑ Other:_____

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

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_____

CVV 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: OUR FACILITY WILL CONFIRM COVERAGE AND VERIFY WHETHER OR NOT THE TEST(S) ORDERED ARE COVERED BY YOUR PLAN.
OUR OFFICE CAN ALSO OBTAIN PRE-AUTHORIZATION FROM THE INSURANCE PLAN.

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_____ INSURANCE AUTH #_____

SECONDARY INSURANCE POLICYHOLDER NAME _____ POLICYHOLDER DOB_____

SECONDARY POLICYHOLDER SS# _____ GENDER:○ M ⊙ F EMPLOYER_____

RELATIONSHIP TO PATIENT_____ POLICY # _____

GROUP #_____ INSURANCE CO. NAME _____

PHONE _____ CLAIMS ADDRESS _____

CITY, STATE, ZIP_____ INSURANCE AUTH #_____

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 OR MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME _____ SIGNATURE_____ DATE _____