



PROVIDER INFORMATION

PATIENT'S INFORMATION

		PATIENT LAST NAME		FIRST NAME		MIDDLE			
		RACE / ETHNICITY <input type="checkbox"/> AMERICAN INDIAN/ ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> HAWAIIAN/PACIFIC ISLANDER <input type="checkbox"/> WHITE							
		GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> OTHER		DOB (MM/DD/YY)		MOBILE PHONE		EMAIL	
		ADDRESS			APT #		CITY		STATE

TESTS

<input type="checkbox"/> <b>CARR</b> CARRIER SCREENING TESTS <input type="checkbox"/> <b>CFXZ</b> CYSTIC FIBROSIS, 60 MUTATIONS <input type="checkbox"/> <b>SMA</b> SPINAL MUSCULAR ATROPHY <input type="checkbox"/> <b>FX</b> FRAGILE X SYNDROME	<b>Specimen &amp; Handling Requirements</b> · 1 lavender tube containing 3-4 mL of whole blood <b>EXCLUSIVE</b> for genetic testing. · Transport EDTA whole blood at Room temperature (20° to 25°C) within 48 hours. Specimens are stable for up to 30 days refrigerated (2° to 8°C).
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REASON FOR TESTING

<input type="checkbox"/> Clinically normal pregnant woman	<input type="checkbox"/> Father has family history of the condition	<input type="checkbox"/> Father is a carrier of the condition
<input type="checkbox"/> Family history of the condition	<input type="checkbox"/> Other _____	

FAMILY HISTORY

Are other relatives known to be affected?  Yes  No If Yes, indicate relationship to patient: \_\_\_\_\_

Are other relatives known to be carriers?  Yes  No If Yes, indicate relationship to patient: \_\_\_\_\_

Have other relatives had molecular genetic testing?  Yes  No If Yes, complete the information below:

Gene: \_\_\_\_\_

Name of individual tested (Last, First, Middle): \_\_\_\_\_

Birth date of individual tested (mm-dd-yyyy): \_\_\_\_\_

Mutations: \_\_\_\_\_

Laboratory at which testing was performed: \_\_\_\_\_

ICD-10 / DIAGNOSES


Please order only if medically necessary and appropriate for individual patients.

PHYSICIAN VISIT NOTES

CHECK LIST

SUBMITTED DOCUMENTS	ON THE REQUISITION FORM	SPECIMEN
<input type="checkbox"/> A copy of the Patient ID <input type="checkbox"/> A copy of the Patient insurance card (front and back) <input type="checkbox"/> Signed copies of the Informed consent <input type="checkbox"/> A signed copy of the Self-pay agreement	<input type="checkbox"/> Detailed patient's information <input type="checkbox"/> ICD-10 codes <input type="checkbox"/> Patient's medical record	<input type="checkbox"/> One whole blood EDTA (Lavender top) tube

VERSION 1.2 REVISED 11/03/23

PHYSICIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_