SaintFrancis Health System Center for Genetic Testing at Saint Francis
Saint Francis Laboratory • 6161 South Yale Avenue • Tulsa, OK 74136
(918) 502-1720 Phone • (918) 502-1723 Fax • (866) 846-0315 Toll Free
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Federal Tax # 73-0700090
Medicare # 370091
CLIA # 37D0474681
CAP # 2050201

MOLECULAR GENETICS LABORATORY TEST REQUISITION

411-001D front / 08-05

PATIENT / SPECIMEN INFORMATION

PATIENT NAME - *LAST, FIRST, MI* ☐ M ☐ F	SSN OR MRN	DATE OF BIRTH

RACE	DIAGNOSIS - *INDICATIONS FOR TESTING*

ICD9	SPECIMEN TYPE	COLLECTION DATE	TIME	CONSENT OBTAINED
				☐ Yes ☐ No

REFERRAL SOURCE

REQUESTING / CONTACT PHYSICIAN	PHONE NUMBER	FAX NUMBER

PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE	FAX RESULTS
	☐ Yes ☐ No

REFERRING FACILITY	PHONE NUMBER	FAX NUMBER

FACILITY ADDRESS, CITY, STATE, ZIP - *IF DIFFERENT FROM ABOVE*	FAX RESULTS
	☐ Yes ☐ No

ADDITIONAL REPORTS TO

MOLECULAR GENETICS TESTS

☐ Achondroplasia (FGFR3)	☐ Hearing Loss - MTTS1	☐ Pseudohypoparathyroidism (GNAS1)
☐ Alagille Syndrome (JAG1) - RNA[5]	☐ Hearing Loss - Pendred Syndrome (SLC26A4)	☐ Rett Syndrome (MECP2)
☐ Alagille Syndrome (JAG1) - DNA[5]	☐ Hearing Loss - Waardenberg, type 1 & 3 (PAX3)	☐ Saethre-Chotzen Syndrome (TWIST)
☐ Albright Hereditary Osteodystrophy (GNAS1)	☐ Hearing Loss - Waardenberg, type 2 (MITF)	☐ SOD1 (ALS, Lou Gehrig's Disease)
☐ ALS (Lou Gehrig's Disease; SOD1)	☐ Hearing Loss - Waardenburg Syndrome panel (PAX3 & MITF)	☐ Spinal & Bulbar Muscular Atrophy (SBMA; Kennedy Disease)
☐ Androgen Insensitivity Syndrome	☐ Hemochromatosis	☐ Spinal Muscular Atrophy, Types 1, 2, & 3 (SMA)
☐ Angelman Syndrome (Methylation)	☐ Huntington Disease (HD)[4]	☐ Spinocerebellar Ataxia, Type 2 (SCA2)
☐ Angelman Syndrome (UPD)[5]	☐ Hypochondroplasia (FGFR3)	☐ Spinocerebellar Ataxia, Type 3 (SCA3; MJD)
☐ Apert's Syndrome (FGFR2)	☐ Hypotonia Panel (DM, PWS, SMA)[3]	☐ Spinocerebellar Ataxia, Type 6 (SCA6)
☐ Beckwith-Weidemann Syndrome (UPD)[5]	☐ Li-Fraumeni Syndrome (p53)[5]	☐ Spinocerebellar Ataxia, Type 7 (SCA7)
☐ Blau Syndrome (NOD2/CARD15 Complete Gene)	☐ Marfan Syndrome - unknown mutation - RNA[5]	☐ Spinocerebellar Ataxia Panel (SCA1, 2, 3, 6, & 7)[3]
☐ Congenital Adrenal Hyperplasia[6] (21-hydroxylase deficiency)	☐ Marfan Syndrome - unknown mutation - DNA[5]	☐ Thyroid Hormone Receptor β
☐ Connexin 26 gene	☐ Marfan Syndrome - known mutation[5]	☐ Uniparental Disomy[5]
☐ Connexin 30 gene	☐ Marfan Syndrome Neonatal exons[5]	*specify chromosome:* _____
☐ Craniodysmorphology Screen (FGFR 1, 2, & 3)	☐ Marfan Syndrome - Linkage[2]	☐ Waardenberg Syndrome Panel (PAX3 & MITF)
☐ Craniodysmorphology Panel (FGFR TWIST)[3]	☐ Maternal Cell Contamination[7]	☐ Waardenberg Syndrome, type 1 & 3 (PAX3)
☐ Crohn's Disease (NOD2/CARD15 Complete Gene)	☐ MCAD	☐ Waardenberg Syndrome, type 2 (MITF)
☐ Crohn's Disease (NOD2 susceptibility markers)	☐ McCune - Albright Syndrome[5]	☐ X-inactivation
☐ Crouzon Syndrome with Acanthosis Nigricans	☐ MECP2 (Rett Syndrome)	☐ Other:
☐ Cystic Fibrosis	☐ MELAS (mt A3243G)	
☐ DRPLA	☐ MERRF (mt A8344G)	**OTHER SERVICES**
☐ Dwarfism Panel[3] (Achondroplasia & Hypochondroplasia)	☐ Mitochondrial Panel (MELAS, MERRF, & NARP)[3]	☐ Custom Single Fragment Sequencing
☐ Dystonia (DYT1)	☐ Mitochondrial Hearing Loss - mt A1555G	☐ Linkage - known allele
☐ EGFR Mutation Analysis[5]	☐ Mitochondrial Hearing Loss - MTTS1	☐ Maternal Cell Contamination
☐ Factor V Leiden	☐ MTHFR	☐ Nucleic Acid Extraction
☐ Familial Adenomatous Polyposis (Linkage)[2]	☐ Myotonic Dystrophy	☐ Sequencing - known mutation
☐ FGFR (FGFR1, 2, & 3)	☐ NARP & Leigh Syndrome (mt T8993G)	
☐ FGFR (FGFR1, 2, 3, & TWIST)[3]	☐ Neurological Panel (HD, SCA, FRDA, DRPLA)[3]	
☐ Fragile X Syndrome	☐ NOD2/CARD15 gene (Crohn's Disease) (4 Markers)	
☐ Friederich's Ataxia (FRDA)	☐ NOD2/CARD15 Complete Gene Analysis	
☐ FTDP (Pick Disease; Tauopathy; MAPT)	☐ P53 (Li Fraumeni Syndrome)	
☐ GNAS1 gene (AHO, PHP1a)	☐ Pendred Syndrome (SLC264A4)	
☐ Hearing Loss (Connexin26)	☐ Pick Disease (FTDP)	
☐ Hearing Loss (Connexin30)	☐ Polycystic Kidney Disease (PKD1 Linkage)[2]	
☐ Hearing Loss - CX Panel (CX26 & CX30)[3]	☐ Polycystic Kidney Disease (PKD2 Linkage)[2]	
☐ Hearing Loss - Full Panel (Cx26&30, mt1555)[3]	☐ Prader-Willi Syndrome (Methylation)	
☐ Hearing Loss - Mitochondrial Mutation A1555G	☐ Prader-Willi Syndrome (UPD)[5]	
☐ Hearing Loss - Mitochondrial Panel (mtA1555G & MTTS-1)	☐ Prothrombin	

2 Cannot be performed on a specimen from a single patient. Family Study, Pedigree REQUIRED
3 Discounted Panel of Tests
4 Consent form MUST accompany specimen (Pre-Symptomatic Patient)
5 Special Instructions : Please Call Laboratory
6 Testing of Parents is STRONGLY recommended when testing prenatal samples
7 REQUIRED for all prenatal testing

CENTER FOR GENETIC TESTING AT SAINT FRANCIS USE ONLY

DATE RECEIVED	TIME	TYPE / AMOUNT RECEIVED	ACCESSION NUMBER

CASE NUMBER	PATIENT NUMBER	INVOICE NUMBER	AUTHORIZATION NUMBER

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BILLING INFORMATION

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PAYMENT INFORMATION - *INDICATE ONE*

☐ **SELF PAY (Payment in Full from Patient or Guarantor)**

☐ Check or Money Order

OTHER	ACCOUNT NUMBER	EXPIRATION DATE
☐ Credit Card ☐ VISA ☐ MC ☐		

CARDHOLDER NAME - *PRINT*	CARDHOLDER - *SIGNATURE*

Payment for Medical Care: It is understood and agreed that the undersigned or a designated agent will be responsible and assume an obligation to pay the Center for Genetic Testing at Saint Francis all costs for genetic evaluation and testing rendered to the person whose name appears within thirty (30) days after having been notified of the amount due and owing or will work out a satisfactory payment plan with the Center for Genetic Testing at Saint Francis. It is further understood and agreed that the undersigned or designated agent will, at all times, remain responsible for the costs of said genetic evaluation and testing.

PATIENT SIGNATURE - *MUST BE 18 YEARS OR OLDER TO SIGN*	DATE

PARENT / LEGAL GUARDIAN - *REQUIRED IF PATIENT IS LESS THAT 18 YEARS OF AGE OR IS NOT LEGALLY COMPETENT*

ADDRESS, CITY, STATE, ZIP	HOME PHONE NUMBER
	( )
EMPLOYER	WORK PHONE NUMBER
	( )
WITNESS - *SIGNATURE*	DATE

Authorization to Release Protected Health Information, Assign Benefits, and Accept Responsibility for My Account: I authorize any physician or laboratory who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Center for Genetic Testing at Saint Francis. I understand that I am responsible for any co-pay or deductible amounts if the Center for Genetic Testing at Saint Francis is a participant in my health plan. I understand I am fully responsible for payment of my account if the Center for Genetic Testing at Saint Francis is not a participant with my health plan, and my health plan does not reimburse (or only partially reimburses) my medical services due to lack of authorization or medical necessity. **The information permitted for release may include records which indicate the presence of a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS), and/or mental health information.**

PATIENT / GUARANTOR - *SIGNATURE*	DATE

☐ **REFERRING FACILITY**

FACILITY NAME	PHONE NUMBER	FAX NUMBER
	( )	( )
BILLING ADDRESS		APPROVAL NUMBER - *IF APPLICABLE*

☐ **OSDH**

AUTHORIZATION NUMBER