# Pediatric Test Requisition Form

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## Patient Information

Name: First _____ MI _____ Last _____
Date of birth (MM/DD/YYYY) _____ Medical record number _____
Sex: ☐ Male ☐ Female ☐ Unknown

## Provider Information

Physician _____ Genetic counselor _____
Phone _____ Fax _____ Email _____
Institution _____ Additional reports to _____

## Clinical Indication

☐ Autism
☐ Developmental delay
☐ Intellectual disability
☐ Failure to thrive
☐ Family history (see box below)
☐ Seizure disorder
☐ Dysmorphic features*
☐ Heart defect*
☐ Multiple anomalies*
☐ Parental specimen
ADx# of child _____
☐ Other*

*Details: _____

## Patient Testing and Family History

Prior genetic testing (provide results and copy of report) _____
*SNP microarray may detect identity by descent.* If parents are related, describe relationship _____
Family history prompting testing (e.g. relationship to patient, ADx#, prior test results/report) _____

## Testing

☐ 100 Rapid microarray (CGH and SNP)
☐ 200 Standard karyotype[1]
☐ 204 Karyotype for mosaicism[1]
☐ 8115 Beckwith-Wiedemann/Russell-Silver methylation testing[1]
☐ 8230 Congenital hypotonia panel[1]
☐ 8380 Fragile X: CGG repeat analysis[1]
☐ 8750 Prader-Willi/Angelman methylation testing[1]
☐ 7500 Maternal cell contamination testing (recommended for cord blood specimens)[1]
☐ Secondary specimen requested by Allele
ADx# _____
☐ Parental testing as recommended in proband report
ADx# _____
☐ Other testing _____

Perform testing in the following order: _____

1 Testing may be performed by a partner laboratory

## Specimen Information

Collection date (MM/DD/YYYY) _____ Time _____ ☐am ☐pm

Sample Type:

☐ Peripheral blood: 2-3 mL NaHep + 2-3 mL EDTA
(Neonates: 1 mL NaHep + 1 mL EDTA)
☐ Cord blood: 2-3 mL NaHep + 2-3 mL EDTA
☐ Buccal swab (OraCollect™)
☐ DNA (specify source) _____
☐ Other (specify source) _____

## Billing

***Institutional Bill***

Institution _____ Contact person _____
Address _____ City, State, Zip _____
Phone _____ Email _____ Fax _____

***Credit Card Payment***

Call 844-255-3532 to pay by credit card. Please see our patient-pay billing policy at allelediagnostics.com/ordering/billing.

Use of Specimens: My (or my child's) sample may be stored indefinitely by Allele Diagnostics, Inc. for quality assurance, test validation, or educational purposes after personal identifiers are removed. I can withdraw my consent at any time by contacting the laboratory at 844-255-3532. Refusal to permit the use of my sample will not affect my test result. All other samples will be retained based on disposal guidelines set forth by the state in which the specimen was collected. By checking this box I am indicating that the sample should be used for the tests ordered on this form and disposed of 60 days after testing is complete. ☐

SAM-F-001v6, 9/2026