Pediatric Cytogenetics/Molecular Cytogenetics Test Requisition Form

120 N. Pine St, Suite 152
Spokane, WA 99202
Phone: 844-ALLELE2 (255-3532)
Fax: 509-232-5779
Email: info@allelediagnostics.com

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/autism spectrum disorder
☐ Developmental delay
☐ Dysmorphic features
☐ Failure to thrive
☐ Heart defect ______________________________
☐ Multiple anomalies ______________________________
☐ Seizure disorder
☐ Short stature
☐ Other ______________________________
☐ Family history of ______________________________
☐ Parental specimen (specify ADx# of child) ______________________________

Patient Testing History and Family History

Prior genetic testing (provide results and copy of report) ______________________________

SNP microarray may detect identity by descent. If parents are known to be related, describe relationship ______________________________

Family member with previous abnormal genetic testing results (specify relationship; provide ADx#, results, or report) ______________________________

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Tests Ordered

☐ 100 Rapid microarray (CGH and SNP)
☐ 200 Standard karyotype
☐ 204 Karyotype for mosaicism
☐ 210 5-cell karyotype + rapid microarray bundle
☐ 8380 Fragile X CGG repeat analysis for blood specimens
☐ 8381 Fragile X CGG repeat analysis for buccal specimens

☐ Secondary specimen requested by Allele (ADx#) ____________________
☐ Parental testing as recommended in proband report (ADx#) ____________________
☐ Other testing ______________________________
____
☐ Perform testing in the following order ______________________________

Specimen Information

Collection date (MM/DD/YYYY)______________ Time____________ ☐am ☐pm

Sample Type:

☐ Peripheral blood (2-3 mL NaHep + 2-3 mL EDTA)
☐ Buccal swab (Use iSWAB™ - DNA Collection Kit)
☐ DNA (specify source) ______________________________
☐ Other (specify source) ______________________________

Billing

Institutional Bill

Institution______________________________ Contact Person ______________________________

Address______________________________ City, State, Zip______________________________

Phone____________________ Email____________________ Fax____________________

Credit Card Payment

Please call 844-ALLELE2 (255-3532) to pay by credit card.

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-ALLELE2 (255-3532). Refusal to permit the use of my sample will not affect my test result. 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. All other samples will be retained based on disposal guidelines set forth by the state in which the ordering physician practices.

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