Pediatric Molecular Genetics Supplemental 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

_____

Specimen Information

Collection date (MM/DD/YYYY) _____ Time _____ ☐am ☐pm
Sample Type: ☐ Peripheral blood (2-3 mL EDTA) ☐ Other (specify source)[1] _____

Tests Ordered[2]

Phenotype-Based Panels

☐ 8230 Congenital hypotonia panel
☐ 8280 Custom NGS panel
(*Specify genes or email gene list to info@allelediagnostics.com*)

Single Gene Testing

☐ 8560 Known mutation evaluation (*specify variant & provide report*) _____
☐ 8830 Single gene sequencing (*specify gene*) _____
☐ 8835 Single gene sequencing and del/dup analysis (*specify gene*) _____

Syndrome-Based Testing

☐ 8115 Beckwith-Wiedemann/Russell-Silver syndrome panel
☐ 8380 Fragile X CGG repeat analysis for blood specimens
☐ 8381 Fragile X CGG repeat analysis for buccal specimens
☐ 8750 Prader-Willi/Angelman syndrome methylation testing

Exome Testing

☐ 8913 Reflex to whole exome *(Complete Pediatric Exome Testing Requisition)*

Additional Testing

☐ Other testing[1] _____

Submission of consultation notes and pedigree is recommended.

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.

Consent Verification

REQUIRED: I verify that I am a licensed/certified healthcare provider (or representative thereof) authorized to order genetic testing. I confirm that the patient has been informed of the benefits and limitations of the testing being ordered and has consented to the testing. Documentation of the informed consent is on file in the patient's medical record. I confirm that testing is medically necessary and that test results may impact medical management for the patient.

Signature of physician/healthcare provider/representative _____ Date _____

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.

[1]*Please contact Allele for assistance before ordering testing or sending a specimen not specified on this requisition.* [2]*Testing performed by a partner laboratory.*