# 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*)

☐ 8760 Proportionate short stature/small for gestational age panel

**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 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

☐ 8790 Russell-Silver syndrome panel

**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.*

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