CompGene

ComprehensiveGeneticServices^{sc}

Patient Name _____

DOB _____ Sex _____

Medical Record # _____ Specimen # _____

Physician _____ Phone # _____

Hospital/Clinic _____

Date / Time Sample Obtained _____

FAX # _____

REQUISITION FOR DNA DIAGNOSTIC SERVICES

Billing Information: Please attach photocopy of payor / responsible party information.

SAMPLE TYPE:

❒ BLOOD 5 ml (1 - 2 ml infants) EDTA (lavender VACUTAINER™)
❒ AMNIOTIC FLUID (≥5 ml unspun)
❒ CULTURED AMNIOCYTES (≥2 confluent T25 flasks required)
❒ CHORIONIC VILLUS mg (5 - 10 mg in PBS or tissue culture medium)
❒ MOUTH BRUSHINGS
❒ OTHER_____ (please specify)

INDICATION:

❒ CONFIRMATION OF DIAGNOSIS
❒ CARRIER STATUS
❒ PRENATAL TESTING (call CompGene)

❒ PREVIOUS FAMILY MEMBER TESTED AT CompGene? CompGene ID#: _____
❒ PREVIOUS FAMILY MEMBER TESTED AT CELTEK? CELTEK ID#:_____
❒ AFFECTED RELATIVE? ❒ YES ❒ NO IF YES, RELATIONSHIP _____ **(Please attach pedigree)**

DNA DIAGNOSTIC ANALYSIS REQUESTED:

❒ ACHONDROPLASIA
❒ α-THALASSEMIA
❒ ANGELMAN SYNDROME
❒ APERT SYNDROME
❒ BCR-ABL BY QPCR (real time)
❒ BECKWITH-WIEDEMANN SYNDROME (methylation and UPD)
❒ β-THALASSEMIA
❒ CONGENITAL ADRENAL HYPERPLASIA (21-hydroxylase deficiency)
❒ CONNEXIN 26 (DFNB1)
❒ CORONAL CRANIOSYNOSTOSIS (FGFR2 and FGFR3)
❒ CYSTIC FIBROSIS (ACOG/ACMG/42 mutation panel)
❒ DNA BANKING
❒ DENTATORUBRAL-PALLIDOLUYSIAN ATROPHY (DRPLA)
❒ DUCHENNE / BECKER MUSCULAR DYSTROPHY
❒ FACTOR V (LEIDEN)
❒ FLT3
❒ FRAGILE X SYNDROME
❒ FRIEDREICH'S ATAXIA
❒ GALACTOSEMIA (GALT deficiency)
❒ HELLP SYNDROME (LCHAD)
❒ HEMOCHROMATOSIS
❒ HEMOPHILIA A
❒ HEMOGLOBIN C
❒ HERED. NEUROPATHY/ LIABILITY PRESSURE PALSIES
❒ HYPEREKPLEXIA (GLRA1)
❒ HUNTINGTON DISEASE
❒ HYPOCHONDROPLASIA
❒ JAK2
❒ LEBER HEREDITARY OPTIC NEUROPATHY
❒ MACHADO-JOSEPH DISEASE (SCA3)
❒ MCAD DEFICIENCY
❒ MOLAR PREGNANCY
❒ MOLECULAR FINGERPRINTING
❒ MOVEMENT DISORDER MUTATION SCREEN
❒ MULTIPLE ENDOCRINE NEOPLASIA (MEN2A/MEN2B) FAMILIAL MEDULLARY THYROID CARCINOMA
❒ MTHFR (methylenetetrahydrofolate reductase deficiency)
❒ MYOTONIC DYSTROPHY
❒ NEONATAL HYPOTONIA PANEL
❒ PATERNITY TESTING
❒ PFEIFFER SYNDROME
❒ POLYHYDRAMNIOS PANEL
❒ PRADER-WILLI SYNDROME
❒ PROTHROMBIN
❒ RET PROTOONCOGENE
❒ RhD and C/c GENOTYPING
❒ SEXING
❒ SICKLE CELL ANEMIA
❒ SKELETAL DYSPLASIA MUTATION PANEL
❒ SPINAL MUSCULAR ATROPHY (WERDNIG-HOFFMAN)
❒ SPINOCEREBELLAR ATAXIA TYPE 2
❒ SPINOCEREBELLAR ATAXIA TYPE 3
❒ SPINOCEREBELLAR ATAXIA TYPE 6
❒ SPINOCEREBELLAR ATAXIA TYPE 7
❒ SPINOCEREBELLAR ATAXIA MUTATION PANEL
❒ SPINOBULBAR MUSCULAR ATROPHY (Kennedy disease)
❒ THANATOPHORIC DYSPLASIA
❒ THROMBOSIS PANEL
❒ UNIPARENTAL DISOMY SCREEN (specify chromosome)
❒ WILLIAMS SYNDROME
❒ ZYGOSITY TESTING

❒ OTHER _____ (Consult with CompGene PRIOR to sending specimen)

Copy of reports to be sent to:_____

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