Molecular Genetics Diagnostic Laboratory

SHIP SPECIMENS TO: Tube Station #829 or Indiana University Department of Medical and Molecular Genetics
550 University Blvd, UH-AOC 6029, Indianapolis IN. 46202-5255 Phone: (317) 944-7597 Fax: (317) 944-4384

PATIENT
NAME: _____
Hospital: _____
MRN: _____
☐ MALE ☐ FEMALE DOB: _____

PHYSICIAN
ORDERING PHYSICIAN: _____
Address: _____
_____
City, State, Zip: _____
Phone/Fax: _____

SAMPLE
DATE COLLECTED: _____
Collected By: _____ Volume: _____
SPECIMEN TYPE:
☐AF ☐CVS ☐BL ☐BM ☐DNA ☐Other: _____
We recommend waiting 6 weeks after a blood transfusion before drawing a blood sample for DNA testing.

CLINICAL
DIAGNOSIS/ICD-10: _____
Test for: ☐ Proband ☐ Carrier ☐ Family Study
If Family Study, Name/Relation: _____
If Pregnant, Gestational age: _____
Mutation, if known: _____
Mutation, if known: _____

BILLING INFORMATION
Bill to: ☐ **Client** ☐ **Patient** (**Insurance/Medicare/Medicaid):**
DEMOGRAPHIC SHEET MUST BE ATTACHED.
Please provide a copy of both the ***FRONT AND BACK*** of insurance card(s).

Medicare No.	Medicaid No.

PRIMARY INSURANCE

Primary Insurance	Primary Ins. No.
Group Name	Group No.
Address	
Insured Name	Relationship

SECONDARY INSURANCE

Primary Insurance	Primary Ins. No.
Group Name	Group No.
Address	
Insured Name	Relationship

Lab Use
Informed Consent Form Received (if applicable): ☐ YES ☐ NO
Date Received _____ Received By _____ Tube(s) _____ Vol _____

*******(SPECIMEN REQUIREMENTS, SHIPPING INSTRUCTIONS, CANCELLATION POLICY ON BACK OF FORM)*******

✓	**DNA TESTS FOR GENETIC DISEASES**
	Fragile X Syndrome (Reflex Southern Blot if needed)
	Prader-Willi/Angelman Syndrome
	Myotonic Dystrophy, DM-1 (Reflex Southern Blot if needed)
	Huntington Disease (**CONSENT FORM REQUIRED**)
	Cystic Fibrosis (*CFTR*)
	☐ Deletion/Duplication Analysis
	☐ Sequence Analysis

✓	**DNA TESTS FOR IDENTITY DETERMINATION**
	BONE MARROW ENGRAFTMENT/CHIMERISM:
	☐ Bone Marrow Sample: Analysis of Total Sample (No T-Cell Separation)
	☐ Blood Sample: Analysis of Whole Blood ONLY (No T-Cell Separation)
	☐ Blood Sample – Analysis of T-Cells ONLY
	☐ Blood Sample – Analysis of Whole Blood AND T-Cells
	☐ **PATIENT**: ☐ Pre-Transplant ☐ Post-Transplant
	Days Post-Transplant: _____ WBC: _____
	☐ **DONOR**: Name: _____
	Relation to Recipient: _____
	OTHER CHIMERISM:
	Organ Transplant. List Type: _____
	☐ Blood Sample: Analysis of Whole Blood ONLY (No T-Cell Separation)
	☐ Blood Sample – Analysis of T-Cells ONLY
	☐ Blood Sample – Analysis of Whole Blood AND T-Cells
	☐ **PATIENT**: ☐ Pre-Transplant ☐ Post-Transplant
	Days Post-Transplant: _____ WBC: _____
	☐ **DONOR**: Name: _____
	Relation to Recipient: _____
	☐ TWIN ZYGOSITY
	MATERNAL CELL CONTAMINATION STUDIES:
	☐ Maternal Sample
	☐ Peripheral Blood ☐ Buccal Swab ☐ Other _____
	☐ Fetal Sample
	☐ CVS ☐ Cord Blood ☐ POC ☐ Umbilical Blood ☐ AF
	☐ Other: _____
	NOTE: Send both maternal and fetal specimens to the Cytogenetics Lab at:
	635 Barnhill Drive, MS 350, Indianapolis, IN 46202
	Phone: 317-274-2243 Fax: 317-278-1616

✓	**DNA SEQUENCING FOR MOLECULAR CARDIOLOGY**
	LQTS Panel (KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2)
	Familial Atrial Fib Panel (KCNQ1, SCN5A, KCNE2, KCNJ2, KCNA5, LMNA)
	Or Select by Individual Gene(s):
	☐ KCNE2 ☐ KCNH2 ☐ SCN5A ☐ KCNE1
	☐ KCNQ1 ☐ KCNJ2 ☐ KCNA5 ☐ LMNA

✓	**NEXT GENERATION SEQUENCING FOR MOLECULAR CARDIOLOGY**
	NGS Cardiomyopathy (CMP) Panel - 62 genes
	NGS HCM Panel - 18 genes
	NGS DCM/LVNC Panel - 33 genes
	NGS ARVC Panel - 8 genes
	NGS Thoracic Aortic Aneurysm Dissection (TAAD) Panel - 18 genes
	NGS Marfan/Loeys-Dietz Panel - 3 genes
	NGS Noonan Spectrum Disorders/RASopathies Panel - 14 genes

✓	**KNOWN VARIANT**	
	Gene: _____	Variant: _____
	Gene Reference Sequence #: _____	

✓	**DNA TESTS FOR MOLECULAR ONCOLOGY**
	PML/RARA t(15;17) PCR analysis of the transcripts:
	☐ Qualitative – Diagnostic
	☐ Qualitative – Diagnostic & Reflex Quantitative
	☐ Quantitative – Minimal Residual Disease
	WT1 expression level analysis
	☐ Quantitative – Minimal Residual Disease

CANCELLATION POLICY
Cancellation of test orders must be received within 48 hours of sample receipt in the laboratory. Testing scheduled for STAT/priority processing cannot be canceled after sample receipt due to adjusted lab processing. To cancel testing, call 317-944-7597 within 48 hours of sample receipt. Note: A handling fee may be assessed for initial processing of the sample prior to test cancellation. To revise requested testing, call 317-944-7597 to determine the status of the patient's sample in lab and discuss available options.

Specimen Requirements

Please label all containers with patient name, MRN, and date of collection. Attach a completed requisition form, including diagnosis with the sample. *Use sterile technique and close all containers tightly. Samples should be delivered to the lab on the same day of collection. If sample is collected after business hours or missed transportation pick-up, please keep sample in the refrigerator or at room temp and deliver to the lab as soon as possible on the next business day. Samples from off site should be shipped at room temperature for overnight delivery directly to the lab address listed at the top front of this requisition form. In hot weather, a cool pack may be enclosed. DO NOT FREEZE*.
Ship Specimens to: *Molecular Genetics Diagnostic Laboratory, Indiana University Department of Medical and Molecular Genetics, 550 University Blvd, UH-AOC 6029, Indianapolis IN. 46202-5255.*

Whole Blood	2-6 mL of whole blood in EDTA (purple-top tube) for routine tests. Ship overnight at room temperature. In hot weather a cool pack may be enclosed. Do not freeze blood.
DNA	Send the DNA specimen in a screw cap tube at least 5 µg of genomic DNA at a concentration of at least 20 ng/µl. Ship overnight at room temperature. In hot weather a cool pack may be enclosed. Note: The sensitivity of our deletion/duplication assay may be reduced when DNA is extracted by an outside laboratory. For best results, please provide a fresh blood sample for this testing.
Bone Marrow	2-5 mL in purple-top EDTA tube (preferred) or yellow-top citric acetate tube. Ship overnight at room temperature. In hot weather a cool pack may be enclosed.
Cell Culture	Ship two T25 flasks of confluent cells or more, sterile, tissue of origin information included. Ship overnight at room temperature. In hot weather a cool pack may be enclosed.
Fetal Sample	Please indicate Gestational age. 20 mL of amniotic fluid in sterile centrifuge tubes or 20 mg of chorionic villi in CVS collecting media. Call the laboratory at 317-274-2246 to order tubes or media. Ship overnight at room temperature. In hot weather a cool pack may be enclosed. Do not freeze. Please call 317-944-7597 when sending fetal samples. Send both maternal and fetal samples to the Cytogenetics Lab at 635 Barnhill Drive, MS 350, Indianapolis, IN 46202.
Buccal Brush	Buccal brush collection kit is available. Please call 317-944-7597 to request. Follow the included instructions to collect buccal brushes. Return buccal brush specimens at ambient temperature.

FINANCIAL INSURANCE WAIVER FORM:

IMPORTANT: Patient and health care providers desiring private insurance billing MUST complete and submit the signed Patient Financial Insurance Waiver Form prior to or at the time of sample submission. *Failure to do so may delay testing/results.*

Financial Responsibility for My Account

I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity or otherwise. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State and Federal law.
A duplicate or faxed copy of this authorization is considered the same as the original document.

Signature of Patient/Responsible Party _____ Printed Name of Patient/Responsible Party _____ Date _____
(Patient/Responsible Party Must be 18 Yrs of Age)

Health Care Providers Please Provide the Following:

1. Provide the patient's diagnosis or ICD-10 code(s) in the "Clinical Info" section on the front page of this form.
2. Indicate billing as requested in the billing section on the front page of this requisition form.
3. if "Patient (Insurance/Medicare/Medicaid)" box has been indicated on front of this form, Include complete patient demographic sheet (if patient is under 18 years of age/child include parent/guardian demographics)
4. Include an enlarged copy of patient's insurance card(s) (both front and back).
5. Ensure the above portion of this Financial Insurance Waiver has been signed by the responsible party.

Patient Authorization for Insurance Benefit Verification

Any necessary prior-authorization should be completed by the health care provider. If the prior-authorization has been completed, please provide the prior authorization number: _____