



Molecular Genetics Diagnostic Laboratory

SHIP SPECIMENS TO: Indiana University Department of Medical and Molecular Genetics

975 W. Walnut St., IB-350, Indianapolis IN. 46202 Phone: (317) 274-7597 Fax: (317) 278-9061

PATIENT	NAME: _____
	Hospital: _____
PHYSICIAN	MRN: _____
	ORDERING PHYSICIAN: _____
	Address: _____
SAMPLE	City, State, Zip: _____
	Phone/Fax: _____
	DATE COLLECTED: _____
	Collected By: _____ Volume: _____
CLINICAL	SPECIMEN TYPE: <input type="checkbox"/> AF <input type="checkbox"/> CVS <input type="checkbox"/> BL <input type="checkbox"/> BM <input type="checkbox"/> DNA <input type="checkbox"/> Other: _____ <i>We recommend waiting 6 weeks after a blood transfusion before drawing a blood sample for DNA testing.</i>
	DIAGNOSIS/ICD-10: _____
	Test for: <input type="checkbox"/> Proband <input type="checkbox"/> Carrier <input type="checkbox"/> Family Study
	If Family Study, Name/Relation: _____
	If Pregnant, Gestational age: _____
Mutation, if known: _____	
Mutation, if known: _____	

BILLING INFORMATION	Bill to: <input type="checkbox"/> Client <input type="checkbox"/> 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): <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Date Received _____ Received By _____ Tube(s) _____ Vol _____	

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

DNA TESTS FOR GENETIC DISEASES	
<input type="checkbox"/>	15q duplication
<input type="checkbox"/>	Cystic Fibrosis (CFTR)
<input type="checkbox"/>	Deletion/Duplication Analysis
<input type="checkbox"/>	Full Sequence Analysis
<input type="checkbox"/>	Targeted Sequence Analysis (must provide variant information)
<input type="checkbox"/>	Fragile X Syndrome (Reflex Southern Analysis, if needed)
<input type="checkbox"/>	Frontotemporal Dementia and/or Amyotrophic Lateral Sclerosis (C9ORF72)
<input type="checkbox"/>	Gilbert Syndrome (UGT1A1) Genotyping
<input type="checkbox"/>	Huntington Disease (CONSENT FORM REQUIRED)
<input type="checkbox"/>	Myotonic Dystrophy, DM-1 (Reflex Southern Analysis, if needed)
<input type="checkbox"/>	Prader-Willi/Angelman Syndrome

DNA SEQUENCING FOR EARLY ONSET INHERITED ALZHEIMER DISEASE	
<input type="checkbox"/>	Panel (APP, GRN, PSEN1, PSEN2)
Or Select by Individual Gene(s):	
<input type="checkbox"/>	APP
<input type="checkbox"/>	PSEN1
<input type="checkbox"/>	PSEN2
<input type="checkbox"/>	MAPT
<input type="checkbox"/>	GRN
<input type="checkbox"/>	Other

DNA TESTS FOR IDENTITY DETERMINATION	
BONE MARROW ENGRAFTMENT/CHIMERISM:	
<input type="checkbox"/>	Bone Marrow Sample: Analysis of Bone Marrow <u>ONLY</u>
<input type="checkbox"/>	Blood Sample: Analysis of Whole Blood <u>ONLY</u>
<input type="checkbox"/>	Blood Sample: Analysis of T-Cells <u>ONLY</u>
	Days Post-Transplant: _____ WBC: _____
<input type="checkbox"/>	PRE-TRANSPLANT RECIPIENT:
<input type="checkbox"/>	PRE-TRANSPLANT DONOR:
	Name: _____
	Relation to Recipient: _____

KNOWN FAMILIAL VARIANT	
Gene: _____	Variant: _____

Gene Reference Sequence #: _____

OTHER CHIMERISM:	
Organ Transplant. List Type: _____	
<input type="checkbox"/>	Blood Sample: Analysis of Whole Blood <u>ONLY</u> (No T-Cell Separation)
<input type="checkbox"/>	Blood Sample – Analysis of T-Cells <u>ONLY</u>
<input type="checkbox"/>	PATIENT: <input type="checkbox"/> Pre-Transplant <input type="checkbox"/> Post-Transplant
	Days Post-Transplant: _____ WBC: _____
<input type="checkbox"/>	DONOR: Name: _____
	Relation to Recipient: _____

DNA TESTS FOR MOLECULAR ONCOLOGY	
<input type="checkbox"/>	PML/RARA t(15;17) PCR analysis of the transcripts:
<input type="checkbox"/>	Qualitative – Diagnostic
<input type="checkbox"/>	Qualitative with Reflex to Quantitative (minimal residual disease monitoring)
<input type="checkbox"/>	WT1 expression level analysis
<input type="checkbox"/>	Quantitative – Minimal Residual Disease

<input type="checkbox"/>	TWIN ZYGOSITY
MATERNAL CELL CONTAMINATION STUDIES:	
<input type="checkbox"/>	Maternal Sample
<input type="checkbox"/>	Peripheral Blood <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Other _____
<input type="checkbox"/>	Fetal Sample
<input type="checkbox"/>	CVS <input type="checkbox"/> Cord Blood <input type="checkbox"/> POC <input type="checkbox"/> Umbilical Blood <input type="checkbox"/> AF
<input type="checkbox"/>	Other: _____
NOTE: Send both maternal and fetal specimens to the Cytogenetics Lab at:	
975 W. Walnut St, IB-350, Indianapolis, IN 46202	
Phone: 317-274-2243 Fax: 317-278-1616	

<input type="checkbox"/>	KIT Targeted sequencing analysis
<input type="checkbox"/>	Exons 8 and 17 (for AML)
<input type="checkbox"/>	Other exons, specify _____

Divisional website: <http://geneticslab.medicine.iu.edu/>

Requisition forms: http://iuhealth.org/images/uploads/iu_molecular_genetics_requisition.pdf

CLIA # 15D0647198 • CAP# 1678930 • Hours of Operation: Monday through Friday, 7:00 am to 4:30 pm

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 317-274-7597 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 317-274-7597 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, 975 W. Walnut St., IB-350, 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. Note: DNA must have been extracted in a CLIA-certified laboratory.
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 317-274-7597 when sending fetal samples. Send both maternal and fetal samples to the Cytogenetics Lab at 975 W. Walnut St., IB-350, Indianapolis, IN 46202.
Buccal Brush	Buccal brush collection kit is available. Please call 317-274-7597 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

(Patient/Responsible Party Must be 18 Yrs of Age)

Printed Name of Patient/Responsible Party

Date

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:
