



Knight Diagnostic Laboratories

Fax: (855) 535-1329
 Email: KDLClientServices@ohsu.edu
 Shipping: 2525 SW 3rd Ave, Ste 350, Portland, OR 97201
 Questions? (855) 535-1522

Molecular Genetics Test Requisition

Patient Information

Full Name
 Street Address
 City, State, Zip
 Phone DOB / /
 Fax Male Female
 ID/MRN #
 Hospital In-Patient Yes No

Ordering Physician Information

Full Name
 NPI
 Office/Facility Name
 Address
 City, State, Zip
 Phone Fax
 Account #
 Notes

Physician Signature _____ Date _____

Send additional copies of test results to:

Physician Name
 Physician Name

Physician Phone Fax
 Physician Phone Fax

Billing Information - Select One Billing Method

Self Pay

Bill Insurance

Attach Copy of Insurance Card or Billing Face Sheet

Bill Referring Provider or Institution

Invoice will be sent to Client Account and Address Listed Above

Primary Insurance Name
 Primary Policy #
 Primary Group #
 Preauthorization #

Secondary Insurance Name
 Secondary Policy #
 Secondary Group #
 Preauthorization #

Relation to Insured Medicaid Medicare
 Self Child Spouse Other _____

Relation to Insured Medicaid Medicare
 Self Child Spouse Other _____

Clinical Information

Specimen Type
 Amniocytes, Cultured
 Amniotic Fluid, Direct
 Blood Spots
 DNA from* _____
 CVS, Direct
 CVS, Cultured
 Whole Blood
 Saliva
 Tissue _____
 Other _____

Date of Specimen Collection / /
 Time of Specimen Collection :
 ICD-10 (required)

Family History / Pedigree

Diagnosis

African American
 Alaska Native
 Asian

Caucasian/ NonHispanic
 Hispanic American
 Jewish, Ashkenazi

Jewish (Other)
 Native American Indian
 Other: _____

*DNA extraction must occur in a CLIA-certified lab or a lab meeting equivalent requirements.

Indication for Testing	Known Familial Mutations
<input type="checkbox"/> Family History, Mutation Known: <input type="checkbox"/> Yes* <input type="checkbox"/> No *If Yes, please complete KNOWN FAMILIAL MUTATIONS <input type="checkbox"/> Symptomatic <input type="checkbox"/> Possible Diagnosis <input type="checkbox"/> Definite Diagnosis <input type="checkbox"/> Carrier Testing <input type="checkbox"/> Presymptomatic Testing <input type="checkbox"/> Prenatal Testing <input type="checkbox"/> Predispositional Testing <input type="checkbox"/> Other (Please Specify) Pregnancy: LMP: _____ GMP: _____	Please call Client Services at 1-855-535-1522 and provide clinical report if proband testing was performed outside of OHSU. Patient Status: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic Name of Gene: _____ Variants to be tested: _____ Name of Proband: _____ Relationship to Proband: _____ OHSU Sample # of Proband: _____ * If proband testing was performed outside of OHSU, please provide clinical report.

Molecular Diagnostic Tests – Next Generation Sequencing Panels

Code	Test Name	Code	Test Name
1000	3-MCC Deficiency	1260	Dilated Cardiomyopathy
1004	Agenesis of the Corpus Callosum	1697	Disorders of Sex Development Panel
1010	Amyotrophic Lateral Sclerosis	1287	Dyslipidemia
2264	Autosomal Dominant Osteogenesis Imperfecta Panel	1295	Dystonia Panel
1158	Arrhythmogenic Right Ventricular Cardiomyopathy	1291	Epilepsy-Seizures
1085	Bone Marrow Failure	1390	Fabry Disease
1090	Brugada Syndrome	1445	Familial Aneurysm and Aortopathy
1151	Cardiomyopathy	1460	Fanconi Anemia
1167	Catecholaminergic Polymorphic Ventricular Tachycardia	1405	Fatty Acid Oxidation Deficiency
1035	Charcot-Marie-Tooth Syndrome	1465	Gluconeogenesis Disorder
1290	Childhood Epilepsy	1495	Hearing Loss
1275	Cholestasis	1610	Heterotaxia
1277	Ciliopathies	1615	High HDL
1153	Comprehensive Arrhythmias	1625	Holoprosencephaly
1095	Comprehensive Brain Malformation	1499	Hypercholesterolemia
1575	Comprehensive Neuromuscular	1645	Hypertriglyceridemias
1475	Congenital Disorders of Glycosylation	1500	Hypertrophic Cardiomyopathy
1285	Congenital Muscular Dystrophy	1655	Hypolipidemia and Hypocholesterolemia
1293	Congenital Muscular Myopathy	1675	Infantile Epilepsy
1165	Connective Tissue Disorders	1691	Inherited Breast Cancer Panel

1245	Craniosynostosis	1696	Inherited Breast/Gyn Cancer panel
1250	Dementia	1690	Inherited Cancer Panel
1693	Inherited Ovarian Cancer Panel	2102	NBIA Del/Dup
1694	Inherited Pancreatic Cancer Panel	1159	Non-Compaction Left Ventricular Cardiomyopathy
1695	Inherited Prostate Cancer Panel	2135	Noonan and Other Related Disorders
1725	Joubert Syndrome	2240	Parkinson's Disease
1297	Limb-Girdle Muscular Dystrophy	2250	Platelet Disorders
2300	Long QT and Short QT Syndromes	2265	Progressive External Ophthalmoplegia
1860	Low HDL	2270	Propionic Acidemia
4870	Lynch Syndrome	2390	Respiratory Chain Deficiency
1990	Macrocephaly	2405	Rett-Angelman Syndrome
1895	Maturity-Onset Diabetes of the Young	2590	SOD and Schizencephaly
2000	Microcephaly	2630	Trifunctional Protein Deficiency
1135	Migraine and Strokes	2640	Urea Cycle Disorder
2142	Monogenic Hypertension Panel	2810	Wilson's Disease
2055	Movement Disorder		
2100	NBIA Sequencing and Del/Dup		
2101	NBIA Sequencing		

Molecular Diagnostic Tests – Single Gene and Targeted Testing

Code	Test Name	Code	Test Name
1001	Achromatopsia, CNGA3/CNGB3 Sequencing	Familial Adenomatous Polyposis (FAP), APC	
Angelman Syndrome		1440	APC Sequencing and Del/Dup
1020	SNRPN Methylation and Del/Dup	1442	APC Sequencing
1030	UBE3A Sequencing	1444	APC Del/Dup
1050	APOL1 Sequencing (exon 6)	1420	Factor V Leiden, R506Q mutation
1160	CPT1A Targeted Mutation, c.1436C → T (p.P479L)	Fanconi Anemia	
1150	Connexin 26, GJB2, Sequencing and Connexin 30, GJB6, Deletion	1450	FANCA Sequencing and Del/Dup
Cystic Fibrosis, CFTR		1448	FANCA Sequencing
1220	CFTR Screening Mutation Panel (60 mutations)	1451	FANCA Del/Dup
1224	CFTR Sequencing and Del/Dup	1452	FANCC Sequencing
1222	CFTR Sequencing	1454	FANCE Sequencing
1226	CFTR Del/Dup	1456	FANCF Sequencing
		1458	FANCG Sequencing
1280	Duchenne/Becker Muscular Dystrophy Del/Dup		

Code	Test Name	Code	Test Name
FMR1-related disorders (including Fragile X), FMR1		Neurodegeneration with Brain Iron Accumulation (NBIA)	
1480	Fragile X Syndrome, FMR1, FMR1-related Primary Ovarian Insufficiency (POI), Fragile X Tremor Ataxia Syndrome (FXTAS)	NBIA NextGen Panel	
		2100	Sequencing and Del/Dup
		2101	Sequencing Only
		2102	Del/Dup Only
Hereditary Hemochromatosis (HH), HFE Mutation		PANK2 (PKAN)	
1600	C282Y (heterozygous results are reflexed to H63D)	2230	Sequencing and Del/Dup
1602	H63D	2231	Sequencing Only
1620	Huntington Disease, HTT repeat expansion Disease-Specific Physician Statement Required	2232	Del/Dup Only
Juvenile Polyposis Syndrome (JPS)		PLA2G6 (INAD)	
1700	BMPR1A Sequencing	1680	Sequencing and Del/Dup
1710	SMAD4 Sequencing	1682	Sequencing Only
Lynch Syndrome (HNPCC)		1681	Del/Dup Only
2028	MLH1 Sequencing	1145	C19orf12 (MPAN), Sequencing
2029	MLH1 Del/Dup	1400	FA2H (FAHN), Sequencing
2030	MLH1 Sequencing and Del/Dup	1550	FTL, Sequencing
2027	MLH1 Promoter Hypermethylation	1080	WDR45 (Beta-Propeller), Sequencing
2032	MSH2 Sequencing	1020 Prader-Willi, SNRPN Methylation Del/Dup	
2033	MSH2 Del/Dup	2290 Prothrombin-Related Mutation, G20210A	
2034	MSH2 Sequencing and Del/Dup	2130 PTPN11 Sequencing	
2036	MSH6 Sequencing	Rett Syndrome (RTT)	
2037	MSH6 Del/Dup	2402	MeCP2 Sequencing and Del/Dup
2038	MSH6 Sequencing and Del/Dup	2400	MeCP2 Sequencing
4870	Sequencing Panel (MLH1, MSH2, and MSH6)	2403	MeCP2 Del/Dup
5020	MEN2, RET, Sequencing	2404	Atypical, CDKL5, Sequencing
2045	MUTYH-Associated Polyposis, MUTYH Sequencing	Sitosterolemia	
2050	Myotonic Dystrophy, DMPK Repeat Expansion	2600	ABCG5 Sequencing
		2610	ABCG8 Sequencing
		2725 von Hippel-Lindau (VHL) Disease, VHL, Sequencing	

Other Laboratory Services

Code	Test Name	Code	Test Name
1300	DNA Banking Services	2900	Zygosity Testing
1980	Maternal Cell Rule Out	1230	Known Mutation/Familial Variant Targeted Mutation Variant(s) Detail:
1240	Full Gene(s) Analysis Please Specify Gene(s):		

NOTICE REGARDING MOLECULAR GENETIC TESTING ON DIRECT CVS OR AMNIOTIC FLUID SPECIMENS

Maternal cell rule-out testing will be performed on all prenatal specimens received. Please provide maternal blood in addition to the fetal specimen sent for genetic testing. Additional charges apply for the maternal cell rule-out test.

All genetic testing performed on direct CVS or Amniotic Fluid specimens will be confirmed on cell cultures prepared by Knight Diagnostic Laboratories. Cell cultures will be prepared from the specimen received. Additional charges apply for confirmatory testing.

Result Release

Results will be immediately available to the patient unless you mark the box below

Do not release (I reasonably believe that an Information Blocking exception applies)

Comments / Requests: