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

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

Physician Signature Date

Ordering Healthcare Provider Information

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

Send additional copies of test results to:

Healthcare Provider Name Provider Phone Fax
Healthcare Provider Name Provider Phone Fax

Billing Information - Select One Billing Method

Billing is done in accordance with the information provided below and OHSU policy. Appropriate areas must be completed or referring laboratory/physician will be billed.

☐ 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 #
Relation to Insured ☐ Medicaid ☐ Medicare
☐ Self ☐ Child ☐ Spouse ☐ Other_____

Secondary Insurance Name
Secondary Policy #
Secondary Group #
Preauthorization #
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:_____

Indications for Testing	Known Familial Mutations
☐ Family History, Mutation Known: ☐ Yes* ☐ No *If Yes, please complete KNOWN FAMILIAL MUTATIONS	Please call Client Services at 1-855-535-1522 and provide clinical report if proband testing was performed outside of OHSU. Patient Status: ☐ Symptomatic ☐ Asymptomatic
☐ Symptomatic	Name of Gene:
☐ Possible Diagnosis	Variant(s) to be tested:
☐ Definite Diagnosis	Name of Proband:
☐ Carrier Testing	Relationship to Proband:
☐ Prenatal Testing	OHSU Sample # of Proband:
☐ Other (Please Specifiy)	*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
☐	2264	Autosomal Dominant Osteogenesis Imperfecta	☐	1690	Inherited Cancer
☐	1085	Bone Marrow Failure	☐	1692	Inherited Colon Cancer
☐	6000	BRCA1 and BRCA2	☐	1693	Inherited Ovarian Cancer
☐	1275	Cholestasis	☐	1694	Inherited Pancreatic Cancer
☐	1277	Ciliopathies	☐	1695	Inherited Prostate Cancer
☐	1165	Connective Tissue Disorders	☐	1895	Maturity-Onset Diabetes of the Young
☐	1245	Craniosynostosis	☐	1135	Migraine and Strokes
☐	1697	Disorders of Sex Development	☐	2142	Monogenic Hypertension
☐	1291	Epilepsy-Seizures	☐	2101	NBIA sequencing
☐	1460	Fanconi Anemia	☐	2135	Noonan and Other Related Disorders
☐	1495	Hearing Loss	☐	2240	Parkinson's Disease
☐	1610	Heterotaxia	☐	2250	Platelet Disorders
☐	1625	Holoprosencephaly	☐	2405	Rett-Angelman Syndrome
☐	1645	Hypercholesterolemia	☐	2590	SOD and Schizencephaly
☐	1691	Inherited Breast Cancer	☐	2810	Wilson's Disease
☐	1696	Inherited Breast/GYN Cancer			

Molecular Diagnostic Tests - Single Gene and Targeted Testing

	Code	Test Name
Angelman Syndrome/Prader-Willi		
☐	1020	SNRPN Methylation and Del/Dup
☐	1050	APOL1 Sequencing (exon 6)
☐	1160	CPT1A Targeted Mutation, c.1346C-> T(p.P479L)
☐	1150	Connexin 26, GJB2, Sequencing and Connexin 30, GJB6, Deletion
Cystic Fibrosis, CFTR		
☐	1220	CFTR Screening Mutation Panel
☐	1224	CFTR Sequencing and Del/Dup
☐	1222	CFTR Sequencing
☐	1226	CFTR Del/Dup
☐	1280	Duchenne/Becker Muscular Dystrophy Del/Dup
☐	1480	Fragile X Syndrome, FMR1, FMR1-related Primary Ovarian Insufficincy (POI), Fragile X Tremor Ataxia Syndrome (FXTAS)
☐	1600	Hereditary Hemochromatosis (HH), HFE, Common Variants
☐	1620	Huntington Disease, HTT repeat expansion Disease-Specific Healthcare Provider Statement Required
Lynch Syndrome (HNPCC)		
☐	2027	MLH1 Promoter Hypermethylation
Lynch Syndrome (HNPCC)		
☐	2027	MLH1 Promoter Hypermethylation
☐	5020	MEN2, RET, Sequencing
☐	2050	Myotonic Dystrophy, DMPK Repeat Expansion

	Code	Test Name
☐	1420	Factor V Leiden, R506Q Mutation
Neurodegeneration with Brain Iron Accumulation (NBIA)		
NBIA NextGen Panel		
☐	2101	NBIA Panel
☐	1145	C19orf12 (MPAN), Sequencing
☐	1400	FA2H (FAHN) Sequencing
☐	1550	FTL (Neurferritinopathy)
☐	2231	PANK2 (PKAN)
☐	1682	PLA2G6 (INAD)
☐	1080	WDR42 (BPAN)
☐	2290	Prothrombin-Related Mutation, G20210A
Rett Syndrome (RTT)		
☐	2402	MECP2 Sequencing and Del/Dup
☐	2400	MECP2 Sequencing
☐	2403	MECP2 Del/Dup

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) Details
☐	1240	Full Gene Analysis Please Specify Gene(s):			

NOTICE REGARDING MOLECULAR GENETIC TESTING

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

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: