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

Physician Signature Date

## Ordering Physician Information

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

## Send additional copies of test results to:

Physician Name Physician Phone Fax
Physician Name Physician 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:_____



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

| Indication for Testing | Known Familial Mutations |
|---|---|
| ☐ Family History, Mutation Known: ☐ Yes* ☐ No<br>*If Yes, please complete KNOWN FAMILIAL MUTATIONS<br>☐ Symptomatic<br>☐ Possible Diagnosis<br>☐ Definite Diagnosis<br>☐ Carrier Testing ☐ Presymptomatic Testing<br>☐ Prenatal Testing ☐ Predispositional Testing<br>☐ Other (Please Specify)<br>Pregnancy: LMP:_____<br>GMP:_____ | Please call Client Services at 1-855-535-1522 and provide clinical report if proband testing was performed outside of OHSU.<br>Patient Status: ☐ Symptomatic ☐ Asymptomatic<br>Name of Gene: _____<br>Variants to be tested: _____<br>Name of Proband:_____<br>Relationship to Proband: _____<br>OHSU Sample # of Proband:_____<br>* 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 Panel | ☐ | 1690 | Inherited Cancer Panel |
| ☐ | 1085 | Bone Marrow Failure | ☐ | 1692 | Inherited Colon Cancer Panel |
| ☐ | 6000 | BRCA1 and BRCA2 | ☐ | 1693 | Inherited Ovarian Cancer Panel |
| ☐ | 1275 | Cholestasis | ☐ | 1694 | Inherited Pancreatic Cancer Panel |
| ☐ | 1277 | Ciliopathies | ☐ | 1695 | Inherited Prostate Cancer Panel |
| ☐ | 1165 | Connective Tissue Disorders | ☐ | 4870 | Lynch Syndrome |
| ☐ | 1245 | Craniosynostosis | ☐ | 1895 | Maturity-Onset Diabetes of the Young |
| ☐ | 1697 | Disorders of Sex Development Panel | ☐ | 1135 | Migraine and Strokes |
| ☐ | 1291 | Epilepsy-Seizures | ☐ | 2142 | Monogenic Hypertension Panel |
| ☐ | 1460 | Fanconi Anemia | ☐ | 2101 | NBIA Sequencing |
| ☐ | 1495 | Hearing Loss | ☐ | 2135 | Noonan and Other Related Disorders |
| ☐ | 1610 | Heterotaxia | ☐ | 2240 | Parkinson's Disease |
| ☐ | 1625 | Holoprosencephaly | ☐ | 2250 | Platelet Disorders |
| ☐ | 1645 | Hypercholesterolemia | ☐ | 2405 | Rett-Angelman Syndrome |
| ☐ | 1691 | Inherited Breast Cancer Panel | ☐ | 2590 | SOD and Schizencephaly |
| ☐ | 1696 | Inherited Breast/Gyn Cancer panel | ☐ | 2810 | Wilson's Disease |

## 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.1436C → T (p.P479L) |
| ☐ 1150 | Connexin 26, GJB2, Sequencing and Connexin 30, GJB6, Deletion |
| **Cystic Fibrosis, CFTR** | |
| ☐ 1220 | CFTR Screening Mutation Panel (60 mutations) |
| ☐ 1224 | CFTR Sequencing and Del/Dup |
| ☐ 1222 | CFTR Sequencing |
| ☐ 1226 | CFTR Del/Dup |
| ☐ 1280 | Duchenne/Becker Muscular Dystrophy Del/Dup |
| **FMR1-related disorders (including Fragile X), FMR1** | |
| ☐ 1480 | Fragile X Syndrome, FMR1, FMR1-related Primary Ovarian Insufficiency (POI), Fragile X Tremor Ataxia Syndrome (FXTAS) |
| **Hereditary Hemochromatosis (HH), HFE Mutation** | |
| ☐ 1600 | C282Y (heterozygous results are reflexed to H63D) |
| ☐ 1602 | H63D |
| ☐ 1620 | Huntington Disease, HTT repeat expansion<br>Disease-Specific Physician Statement Required |
| **Lynch Syndrome (HNPCC)** | |
| ☐ 2027 | MLH1 Promoter Hypermethylation |
| ☐ 4870 | Sequencing Panel (MLH1, MSH2, and MSH6) |
| ☐ 5020 | MEN2, RET, Sequencing |
| ☐ 2050 | Myotonic Dystrophy, DMPK Repeat Expansion |

| Code | Test Name |
|---|---|
| ☐ 1420 | Factor V Leiden, R506Q mutation |
| **Hereditary Hemochromatosis (HH), HFE Mutation** | |
| ☐ 1600 | C282Y (heterozygous results are reflexed to H63D) |
| ☐ 1602 | H63D |
| ☐ 1620 | Huntington Disease, HTT repeat expansion<br>Disease-Specific Physician Statment Required |
| **Neurodegeneration with Brain Iron Accumulation (NBIA)** | |
| NBIA NextGen Panel | |
| ☐ 2101 | Sequencing Only |
| PANK2 (PKAN) | |
| ☐ 2230 | Sequencing and Del/Dup |
| ☐ 2231 | Sequencing Only |
| ☐ 2232 | Del/Dup Only |
| PLA2G6 (INAD) | |
| ☐ 1680 | Sequencing and Del/Dup |
| ☐ 1682 | Sequencing Only |
| ☐ 1681 | Del/Dup Only |
| ☐ 1145 | C19orf12 (MPAN), Sequencing |
| ☐ 1400 | FA2H (FAHN), Sequencing |
| ☐ 1550 | FTL, Sequencing |
| ☐ 1080 | WDR45 (Beta-Propeller), Sequencing |
| ☐ 2290 | Prothrombin-Related Mutation, G20210A |
| **Rett Syndrome (RTT)** | |
| ☐ 2402 | MeCP2 Sequencing and Del/Dup |
| ☐ 2400 | MeCP2 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<br>Variant(s) Detail: |
| ☐ | 1240 | Full Gene(s) Analysis<br>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 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: