



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

Prenatal 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

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.

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, Direct Date of Specimen Collection / /
 Amniotic Fluid, Cultured Time of Specimen Collection : :
 Blood Spots ICD-10: (required)
 DNA from*
 CVS, Direct
 CVS, Cultured
 Whole Blood
 Saliva
 Tissue
 Other

Family History / Pedigree

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

African American

Caucasian/ Non-Hispanic

Jewish (Other)

Alaska Native

Hispanic American

Native American Indian

Asian

Jewish, Ashkenazi

Other:

Indication for Testing	Known Familial Mutations
Family History, Mutation Known: Yes* No *If Yes, please complete KNOWN FAMILIAL MUTATIONS Symptomatic Possible Diagnosis Definite Diagnosis Carrier Testing Presymptomatic Testing Prenatal Testing Predispositional Testing Other (Please Specify) Pregnancy: LMP: _____ GMP: _____	Please call Client Services at 1-800-KDL-1LAB and provide clinical report if proband testing was performed outside of OHSU. Patient Status: Symptomatic Asymptomatic Name of Gene: _____ Variants to be tested: _____ Name of Proband: _____ Relationship to Proband: _____ OHSU Sample # of Proband: _____

Chromosome Studies

- 6020 Amniotic Fluid Chromosome Study
- 6054 High Resolution Blood Chromosome Study
- 6100 Chorionic Villus Sample (CVS) Chromosome Study
- 6750 Tissue Chromosome Study

All Chromosome studies will reflex to FISH if clinically relevant abnormalities are detected; appropriate charges will apply.

Molecular Diagnostic Tests

Code	Test Name
1001	Achromatopsia, CNGA3/CNGB3 Sequencing
Angelman Syndrome	
1020	SNRPN Methylation and Del/Dup
1030	UBE3A Sequencing
1080	Beta-Propeller Protein-Associated Neurodegeneration, WDR45 Sequencing
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
Familial Adenomatous Polyposis (FAP), APC	
1440	APC Sequencing and Del/Dup
1442	APC Sequencing
1444	APC Del/Dup
1160	CPT1A Targeted Mutation, C.1436 C-->T(p.P479L)
Fanconi Anemia	
1450	FANCA Sequencing and Del/Dup
1448	FANCA Sequencing
1451	FANCA Del/Dup

Code	Test Name
1452	FANCC Sequencing
1454	FANCE Sequencing
1456	FANCF Sequencing
1458	FANCG Sequencing
1460	Fanconi Anemia NextGen Sequencing Panel
1280	Duchenne/Becker Muscular Dystrophy (DMD) Del/Dup
1400	Fatty Acid Hydroxylose-Associated Neurodegeneration (FAHN), FA2H Sequencing
1480	Fragile X Syndrome, FMR1
1620	Huntington Disease (HD), HTT repeat expansion analysis - Disease-Specific Physician Statment Required
Infantile Neuroaxonal Dystrophy (INAD), PLA2G6	
1680	PLA2G6 Sequencing and Del/Dup
1682	PLA2G6 Sequencing
1681	PLA2G6 Del/Dup
Juvenile Polyposis Syndrome (JPS)	
1700	BMPR1A Sequencing
1710	SMAD4 Sequencing
1145	Mitochondrial-membrane Protein-Associated Neurodegeneration (MPAN), C19orf12 Sequencing
Mitochondrial Studies	
2020	MELAS

Code	Test Name
2022	MERRF
2024	NARP
2026	Mitochondrial Del/Dup
2045	MUTYH-Associated Polyposis (MAP), MUTYH (MYH) Sequencing
2050	Myotonic Dystrophy type 1 (DM), DMPK Repeat Expansion Analysis
5020	MEN2, RET, Sequencing
1550	Neuroferritinopathy, FTL, Sequencing
2135	Noonan and Other Related Disorders
2130	PTPN11 Sequencing
Pantothenate Kinase Associated Neurodegeneration (PKAN), PANK2	
2230	PANK2 Sequencing and Del/Dup
2231	PANK2 Sequencing
2232	PANK2 Del/Dup
1020	Prader-Willi Syndrome, SNRPN Methylation Del/Dup

Code	Test Name
Rett Syndrome (RTT)	
2402	MeCP2 Sequencing and Del/Dup
2400	MeCP2 Sequencing
2403	MeCP2 Del/Dup
2404	CDKL5 Sequencing (Atypical Rett)
Sitosterolemia	
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	Zygoty Testing
1980	Maternal Cell Rule Out	1230	Known Mutation/Familial Variant Targeted Mutation Analysis Variant Detail:
1240	Full Gene(s) Analysis Gene(s) Detail:		

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.