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

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

Provider 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, Direct
☐ Amniotic Fluid, Cultured
☐ 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

☐ African American
☐ Alaska Native
☐ Asian
☐ Caucasian/ Non-Hispanic
☐ Hispanic American
☐ Jewish, Ashkenazi
☐ Jewish (Other)
☐ Native American Indian
☐ 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
Angelman Syndrome / Prader-Willi		
☐	1020	SNRPN Methylation and Del/Dup
☐	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
☐	1160	CPT1A Targeted Mutation, C.1436 C-->T(p.P479L)
☐	1460	Fanconi Anemia NextGen Sequencing Panel
☐	1280	Duchenne/Becker Muscular Dystrophy (DMD) Del/Dup
☐	1480	Fragile X Syndrome, FMR1
☐	1620	Huntington Disease (HD), HTT repeat expansion analysis - Disease-Specific Physician Statment Required
☐	2050	Myotonic Dystrophy type 1 (DM), DMPK Repeat Expansion Analysis
☐	5020	MEN2, RET, Sequencing
☐	2135	Noonan and Other Related Disorders

	Code	Test Name
Neurodegeneration with Brain Iron Accumulation (NBIA)		
☐	2101	NBIA Panel
☐	1145	C19orf12 (MPAN), Sequencing
☐	1400	FA2H (FAHN), Sequencing
☐	1550	FTL (Neurferritinopathy)
☐	2231	PANK2 (PKAN)
☐	1682	PLA2G6 (INAD)
☐	1080	WDR42 (BPAN)
Rett Syndrome (RTT)		
☐	2402	MECP2 Sequencing and Del/Dup
☐	2400	MECP2 Sequencing
☐	2403	MECP2 Del/Dup

Other Laboratory Services

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

NOTICE REGARDING MOLECULAR GENETIC TESTING ON PRENATAL SPECIMENS

Maternal cell rule-out testing will be performed on all prenatal specimens recieved. Please provide maternal blood or saliva in additon 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: