MOLECULAR DIAGNOSTIC LABORATORY
Barnes-Jewish Hospital, Institute of Health
425 South Euclid Avenue
Room 5970, Mailstop #90-28-344
St. Louis, MO 63110
(314) 454-8685; (314) 454-7601; FAX (314) 454-7616
URL: http://pathology.wustl.edu/patientcare/moldiagnostic.php

Request For DNA Studies
MEDICAL GENETICS

COLLECTION INFORMATION: ☐ AM ☐ PM

DATE ______________ TIME ______________ INITIALS ___________

ACCOUNT INFORMATION

NAME

ADDRESS

CITY STATE ZIP

PHONE

FAX

ORDERING PHYSICIAN

SECOND REPORT TO

ACCOUNT	PATIENT ACCT.	RESEARCH ACCT.

THIS SECTION FOR LAB USE ONLY

PATIENT ID	NO. SPEC RECEIVED	REGISTERED BY	VERIFIED BY

PATIENT INFORMATION

PATIENT LAST NAME OR ID#	FIRST	DOB	SEX

RACE (see back)	ETHNICITY (see back)	DIAGNOSIS CODE	SSN

PATIENT'S ADDRESS	CITY	STATE	ZIP	PHONE

BILLING INFORMATION } **BILL TO:** ☐ ACCOUNT ☐ PATIENT ☐ INSURANCE ☐ RESEARCH ACCT.

☐ Medicare ☐ Medicaid ☐ CARE PARTNERS ☐ PARTNERS HMO

ID #__________________ ALPHA Code_____________ ☐ GHP ☐ OTHER_____________

INSURANCE CO.	I.D.#
ADDRESS	GRP.#
INSURED NAME (IF NOT PATIENT)	PLAN NAME

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Laboratory Use Only:

Specimen Condition: ____

Specimen Number: ____

Date Received: ________________________ Time Received: ______________

Tube Type:

☐ EDTA

☐ ACD

☐ OTHER: ______________________

For Children: Father's Name: ______________________________ City: ______________________________

Mother's Name: ______________________________ State: ______________ Zip Code: ________

Diagnostic Test: ☐ Fragile X Syndrome

☐ Fragile X-Associated Tremor & Ataxia Syndrome FXTAS

☐ Factor 5 Leiden (FVL) Mutation

☐ Prothrombin (Factor 2) Mutation

☐ MTHFR C677T Mutation

Reason for Study: ☐ Diagnostic Testing ☐ Carrier Detection ☐ Prenatal Diagnosis ☐ Routine ☐ STAT

☐ Has genetic counseling by an authorized person been offered? (5946, 5953 exempted)

☐ Has informed consent been obtained from the consultant and/or guardian?

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For CF Study Only: Ethnic Origins: Father: ___________________________ Mother: ___________________________

Please enter a short pedigree and any other clinical information below

Patient Demographic Information:

Race:	American Indian or Alaska Native	AI
	Asian	AS
	Black or African American	BL
	Native Hawaiian or other Pacific Islander	PI
	White	WH
	Unknown	UN
	Some other Race	SR
Ethnicity:	Hispanic or Latino	002
	Non Hispanic or Latino	003
	Unknown	004

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BARNES-JEWISH Hospital
BJC HealthCare

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	Native Hawaiian or other Pacific Islander	PI
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	Unknown	UN
	Some other Race	SR
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	Non Hispanic or Latino	003
	Unknown	004

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	Unknown	004