Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Molecular Genetics Laboratory

4800 Sand Point Way NE OC.8.720
Seattle, WA 98105 (206) 987-2102
http://seattlechildrenslab.testcatalog.org

FAILURE TO COMPLETE MAY DELAY RESULTS

Patient's Last Name	First	Middle	Birth date	Sex

Outside Patient Number	Outside Specimen Number	Send Report To:

Ordering Provider	Address:

Provider Phone Number	DIAGNOSIS / ICD CODE:	Phone:	Fax:

IMPORTANT INFORMATION REGARDING BILLING AND MEDICAL NECESSITY ON BACK

FAX ADDITIONAL RESULTS TO:
NAME: FAX #:

HEALTHCARE PROFESSIONAL TO CALL FOR INFO/ABNORMAL RESULTS:
NAME: PHONE #:

SPECIMEN INFORMATION

Date collected: _____ Specimen: ☐ Blood, EDTA or ACD ☐ Extracted DNA, source: _____

Time collected: _____ ☐ Saliva (OrageneDx OGD-575/675 only) ☐ Tissue, fresh frozen or FFPE, source: _____

PATIENT/FAMILY HISTORY REQUIRED - ATTACH RELEVANT CLINIC NOTES

Clinical information provided will aid in interpretation, decrease testing delays and improve reporting.

REASON FOR STUDY: ☐ Diagnostic (affected) ☐ Diagnostic (not affected) ☐ Carrier Testing (affected family member) ☐ Carrier Testing (no family history)

CLINICAL FINDINGS, PREVIOUS RELEVANT GENETIC TEST RESULT(S), FAMILY HISTORY: _____

ETHNICITY: _____ **PATIENT PREGNANT?** ☐ NO ☐ YES Estimated due date: _____

DNA ANALYSIS

Test information, specimen requirements & gene lists available at: http://seattlechildrenslab.testcatalog.org

For reflex testing, check all boxes that apply:

CRANIOSYNOSTOSIS
- ☐ Craniosynostosis Seq - Focused Panel - 7 genes ☐ Deletion/Duplication Analysis
- ☐ Craniosynostosis Seq - Expanded Panel - 49 genes

DIABETES
- ☐ Congenital Hyperinsulinism (CHI) Sequencing Panel - 9 genes
- ☐ Maturity Onset Diabetes of the Young (MODY) Sequencing Panel - 15 genes
- ☐ Neonatal Diabetes (NDM) Sequencing Panel - 23 genes
- ☐ Deletion/Duplication Analysis

DIFFERENCES IN SEX DEVELOPMENT (DSD)
- ☐ DSD Sequencing Panel - 56 genes ☐ Deletion/Duplication Analysis

ENCEPHALOCRANIOCUTANEOUS LIPOMATOSIS/OCULOECTODERMAL SYNDROME
- ☐ ECCL/OES Sequencing (FGFR1/KRAS) Panel - 2 genes

INTERSTITIAL LUNG DISEASE
- ☐ Childhood Interstitial Lung Disease (chILD) Sequencing - Expanded Panel - 48 genes
- ☐ chILD Seq - Rapid Neonatal Panel - 9 genes
- ☐ Deletion/Duplication Analysis

INTESTINAL PSEUDO-OBSTRUCTION
- ☐ Intestinal Pseudo-Obstruction Seq Panel - 12 genes ☐ Deletion/Duplication Analysis

RETT/ANGELMAN SYNDROME
- ☐ Rett/Angelman Syndrome Seq Panel - 16 genes ☐ Deletion/Duplication Analysis

VASCULAR ANOMALIES
- ☐ Cerebral Cavernous Malformations (CCM) Sequencing Panel - 3 genes
- ☐ Hereditary hemorrhagic telangiectasia (HHT) Sequencing Panel - 6 genes
- ☐ VANSeq - Capillary Malformation Panel - 4 genes
- ☐ VANSeq - Lymphatic/Venous/Arteriovenous Malformations (LM/VM/AVM) Panel - 17 genes
- ☐ VANSeq - Lymphedema Panel - 23 genes
- ☐ VANSeq - Vascular Tumor Panel - 10 genes
- ☐ VANSeq - Expanded Panel - 44 genes

Common VANSeq single gene request:
- ☐ PDGFRB Seq - Isolated aneurysm/infantile myofibromatosis/Penttinen syndrome
- ☐ PIK3CA related overgrowth spectrum (PIK3CA) Sequencing
- ☐ Deletion/Duplication Analysis

- ☐ 22q11.2 Deletion/Duplication by MLPA (22q11.2 DS, DiGeorge, VCFS)
- ☐ Connexin 26/30 (GJB2 Sequencing with reflex to common deletion analysis of GJB6)
- ☐ Connexin 30 (GJB6) Sequencing
- ☐ DNA Banking **ONLY** **Separate Consent Form Required** links: English Spanish
- ☐ Fragile X DNA (FMR1)
- ☐ Galactosemia (GALT) Common Variants Panel (8 variants)
- ☐ Gaucher Disease (GBA) Panel (11 variants)
- ☐ Gaucher (GBA) Sequencing
- ☐ LCHAD/TFP (HADHA) Sequencing
- ☐ LCHAD/TFP (HADHB) Sequencing
- ☐ Lysosomal Acid Lipase (LIPA) Sequencing (Wolman Disease/CESD)
- ☐ MCAD (ACADM) Sequencing
- ☐ Pendred (SLC26A4) Sequencing
- ☐ Polymerase Gamma (POLG) Sequencing
- ☐ Polymerase Gamma 2 (POLG2) Sequencing
- ☐ Pompe (GAA) Sequencing
- ☐ Prader-Willi/Angelman Methylation and Deletion/Duplication by MS-MLPA
- ☐ Primary Hyperoxaluria Type 1 (AGXT) Sequencing
- ☐ Pyridoxine-Dependent Seizures (ALDH7A1) Sequencing
- ☐ Spinal Muscular Atrophy Diagnostic (SMN1 & SMN2 copy number)
- ☐ Spinal Muscular Atrophy Carrier Testing (SMN1 copy number)
- ☐ Tyrosinemia type 1 (FAH) Panel (6 variants)
- ☐ VLCAD (ACADVL) Sequencing
- ☐ Wilson Disease (ATP7B) Sequencing

SINGLE GENE ANALYSIS from SCH panels
☐ Sequencing ☐ Deletion/Duplication Analysis

GENE(S): _____

TARGETED VARIANT ANALYSIS (Information Below is Required for this Testing)

GENE: _____

VARIANT(S): _____

PROBAND*: _____ **RELATIONSHIP:** _____

*If relative was not tested at Seattle Children's Laboratory, please contact the Laboratory Genetic Counselors (206-987-5400) for approval of testing prior to submitting samples.

BILLING INFORMATION

PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

BILLING NOTIFICATION: All samples will be billed to the referring institution unless complete billing and diagnosis information is provided on this form. Contact Seattle Children's Laboratory Client Services for additional assistance (206) 987-2617.

BILL TO:

☐ **Referring Institution (Preferred)** - Provide billing address or stamp institution's information.
(Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients.)

Billing Address:	Billing Contact Name:
Billing Contact Phone/Fax:	Billing Contact Email:

☐ **Primary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		Employer
Primary Care Physician		Phone Number
Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Secondary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Self Pay**- First, call Lab Client Services for pricing. Then, provide credit card information below or enclose a check with the sample.

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		
Name on Credit Card	Payment Amount	CVN
Card Number	Card Type	Expiration

Please visit our test catalog at http://seattlechildrenslab.testcatalog.org for testing information or call:

Lab Genetic Counselors (206) 987-5400 Lab Client Services (206) 987-2617 Molecular Genetics Lab (206) 987-3872

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Ship to: LABORATORY
4800 Sand Point Way NE, M/S: OC.8.720
SEATTLE, WA 98105