Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

Biochemical Genetics

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

Patient's Last Name	First	Middle	Birth date (required)	Sex
Outside Patient Number	Outside Specimen Number	Send Report To		
Ordering Provider		Address		
Phone Number	Diagnosis/ICD Code	Phone/Fax		

REQUIRED SPECIMEN INFORMATION:

DATE COLLECTED: _____/_____/__________ ☐ Whole Blood ☐ Serum/Plasma ☐ Urine
TIME COLLECTED: ______:______ AM/PM ☐ Skin ☐ Other_______________

BLOOD

- ☐ **ACYLCARNITINE PROFILE, BLOOD**
- ☐ **AMINO ACID, QUANTITATIVE**
- ☐ **SINGLE AMINO ACID, SPECIFY:**
- ☐ **ALPHA-AMINOADIPIC SEMIALDEHYDE (needs STAT processing)**
- ☐ **CARNITINE, PLASMA**
- ☐ **G-6-PD SCREEN**
- ☐ **GALACTOSE-1-PHOSPHATE URIDYL TRANSFERASE, QUANTITATIVE**
- ☐ **GALACTOSE-1-PHOSPHATE**
- ☐ **HOMOCYSTEINE (TOTAL), QUANTITATIVE**
- ☐ **METHYLMALONIC ACID, QUANTITATIVE**
- ☐ **MSUD MONITORING**
- ☐ **NTBC (ORFADIN) LEVEL**
- ☐ **PHENYLALANINE/TYROSINE, QUANTITATIVE**
- ☐ **PIPECOLIC ACID**
- ☐ **VERY LONG CHAIN FATTY ACIDS, PHYTANIC, PRISTANIC**
- ☐ **BIOTINIDASE**

LYSOSOMAL ENZYMES by DISEASE

- ☐ **CEROID LIPOFUSCINOSIS-CLN1** (palmitoyl-protein thioesterase) (L,F, DBS)
- ☐ **CEROID LIPOFUSCINOSIS-CLN2** (tripeptidyl peptidase) (L, F, DBS)
- ☐ **FABRY** (alpha-galactosidase) (L, F, DBS)
- ☐ **FUCOSIDOSIS** (alpha-fucosidase) (L, F)
- ☐ **GAUCHER** (beta-glucosidase) (L, F)
- ☐ **GM1 GANGLIOSIDOSIS** (beta-galactosidase) (L, F)
- ☐ **GM2 GANGLIOSIDOSIS (TAY SACHS, Sandhoff)** (Hexosaminidase, A+B) (F, S)
- ☐ **HURLER** (alpha-iduronidase) (L, F)
- ☐ **MORQUIO** (galactose-6-sulfatase, MPS IVa) (L, F)
- ☐ **I CELL DISEASE** (Hexosaminidase, A+B) (S)
- ☐ **MANNOSIDOSIS** (alpha-mannosidase) (L,F)
- ☐ **MANNOSIDOSIS** (beta-mannosidase) (L,F)
- ☐ **MAROTEAX-LAMY** (Arylsulfatase B) (L,F)
- ☐ **MLD** (Arylsulfatase A) (L,F)
- ☐ **POMPE** (alpha-glucosidase, acid maltase) (F, DBS)
- ☐ **SLY** (beta-glucuronidase) (L,F)
- ☐ **WOLMAN, CHOLESTERYL ESTER STORAGE** (lysosomal acid lipase) (DBS)

F=Fibroblasts DBS=Dried Blood Spot L=Leukocytes S=Serum

FIBROBLASTS/TISSUE

- ☐ **FIBROBLAST CULTURE**
- ☐ **LYSOSOMAL ENZYME, FIBROBLAST-SPECIFY:**

URINE

- ☐ **AMINO ACIDS, QUANTITATIVE URINE**
- ☐ **CARNITINE, URINE**
- ☐ **CYSTINE, QUANTITATIVE URINE**
- ☐ **HOMOCYSTINE, QUANTITATIVE URINE**
- ☐ **MUCOPOLYSACCHARIDE, QUANTITATIVE URINE**
- ☐ **MUCOPOLYSACCHARIDE, ELECTROPHORESIS**
- ☐ **OLIGOSACCHARIDES, URINE**
- ☐ **ORGANIC ACIDS, URINE**
- ☐ **SUCCINYLLACETONE SCREENING, URINE**
- ☐ **SUCCINYLACETONE QUANTITATION, URINE**
- ☐ **SULFHYDRYL GROUPS, QUALITATIVE URINE**
- ☐ **SULFITE, DIPSTICK URINE**

PATIENT INFORMATION

CURRENT DIET:____

DRUGS ADMINISTERED WIHTIN PREVIOUS 72 HOURS:______________________________

PATIENT HISTORY: ☐ Seizures ☐ Metabolic Disease ☐ Other:______________________
☐ Retardation ☐ Renal Disease ☐ Liver Disease ☐ Hepatomegaly ☐ Dyslipidemia

CLINICAL HISTORY/REASON FOR SUBMITTING SAMPLE:______________________________
____

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:

Dr. Sihoun Hahn, MD PhD (206) 987-7610 Dr. Rhona Jack, PhD (206) 987-2569 Biochemical Genetics Lab (206) 987-2216

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