THE UNIVERSITY OF CHICAGO GENETIC SERVICES LABORATORIES

REQUISITION FORM

5841 South Maryland Avenue, Room G701/MC0077, Chicago, IL 60637
Toll Free: (888) 824-3637 • Local: (773) 834-0555 • Fax: (312) 729-2808
ucgslabs@genetics.uchicago.edu • dnatesting.uchicago.edu
CLIA#: 14D0917593 • CAP#: 18827-49

****Necessary for testing:** **ICD9:** _____

Indication for testing: _____

Results of previous genetic testing: _____

_____

PATIENT INFORMATION

NAME: Last _____ First _____ **MRN:** _____

DOB: _____ ☐ **MALE** ☐ **FEMALE** **ETHNICITY:** ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Ashkenazi Jewish ☐ Other: _____

PATIENT'S MOTHER/FATHER: _____

REPORTING RESULTS: Reports will only be faxed out. All abnormal and prenatal results will also be called out. Please check the boxes below for those who should receive the report by fax.

☐ **REF MD:** _____
PHONE: _____
FAX: _____
E-MAIL: _____

☐ **GC:** _____
PHONE: _____
FAX: _____
E-MAIL: _____

☒ **REF LAB:** _____ ☐ **SEND-OUT COORDINATOR:** _____
PHONE: 800-533-1710 FAX: 507-538-5340

SAMPLE INFORMATION

- All samples should be shipped via overnight delivery at room temperature to the address at the top of this page.
- **No weekend or holiday deliveries**
- Label each specimen with the patient's name, date of birth and date sample collected
- Send specimens with this requisition **COMPLETELY** filled out otherwise, specimen processing will be delayed.

Specimen requirements:

*Routine tests: **3-10cc blood in an EDTA (purple top) tube (unless otherwise indicated)

*Prenatal tests: 20cc amniotic fluid, 20mgs chorionic villi, or 2 T25 flasks of cultured cells

For all prenatal testing: please send 3-10cc of mother's blood in an EDTA/purple top tube to rule out maternal cell contamination

DATE SAMPLE DRAWN: _____

Specimen Type: ☐ Amniotic Fluid ☐ Chorionic Villi ☐ Peripheral blood ☐ DNA ☐ Product of Conception (POC) ☐ Culture: _____ ☐ Other: _____

Gestational Age: _____ weeks by ☐ LMP ☐ Ultrasound

See our QuickGuide to Genetic Testing for complete list of Costs, TAT, and CPT codes

TEST(S) REQUESTED

Angelman/Prader-Willi syndromes testing

☐ Angelman Syndrome Series (MS-MLPA and Tier 2, if negative)
☐ MS-MLPA for PWS ☐ MS-MLPA for AS
☐ UPD15
☐ Imprinting center deletion analysis
☐ *UBE3A* Sequencing ☐ *UBE3A* Del/Dup (by array-CGH)
☐ *SLC9A6* Sequencing ☐ *SLC9A6* Del/Dup (by array-CGH)
☐ Angelman Syndrome Tier 2 Panel (*MECP2, TCF4, SLC9A6, UBE3A* sequencing and del/dup by array-CGH)

Brain malformation testing

Lissencephaly Testing:

☐ Lissencephaly panel (*LIS1, DCX* sequencing & del/dup by MLPA, *TUBA1A* sequencing)
☐ *DCX* Sequencing ☐ *DCX* Del/Dup (by MLPA)
☐ *LIS1* Sequencing ☐ *LIS1* Del/Dup (by MLPA)
☐ *TUBA1A* Sequencing Only
☐ *ARX* Sequencing ☐ *ARX* Del/Dup (by MLPA)

Microcephaly Testing:

☐ *ASPM* Sequencing ☐ *ASPM* Del/Dup (by array-CGH)
☐ MCPH Tier 2 Panel (*CDK5RAP2, CENPJ, MCPH1,* and *STIL* sequencing and del/dup by array-CGH, *CEP152* sequencing)
☐ *CEP152* Sequencing Only
☐ *PNKP* Sequencing Only
☐ *WDR62* Sequencing Only
☐ *NDE1* Sequencing Only

Other Brain Malformation Testing:

☐ *CASK* Sequencing ☐ *CASK* Del/Dup (by array-CGH)
☐ *GPR56* Sequencing ☐ *GPR56* Del/Dup (by array-CGH)
☐ *OPHN1* Sequencing ☐ *OPHN1* Del/Dup (by array-CGH)
☐ *TSEN54* Sequencing ☐ *TSEN54* Del/Dup (by array-CGH)
☐ *TUBB2B* Sequencing Only

Centronuclear/myotubular myopathy testing

☐ *BIN1* Sequencing ☐ *BIN1* Del/Dup (by array-CGH)
☐ *DNM2* Sequencing ☐ *DNM2* Del/Dup (by array-CGH)
☐ *MTM1* Sequencing ☐ *MTM1* Del/Dup (by array-CGH)

CHARGE syndrome testing

☐ *CHD7* Sequencing ☐ *CHD7* Del/Dup (by MLPA)

Chondrodysplasia punctata testing

☐ *ARSE* Sequencing ☐ *ARSE* Del/Dup (by array-CGH)
☐ *EBP* Sequencing ☐ *EBP* Del/Dup (by array-CGH)

Cornelia de Lange syndrome testing

☐ CdLS Series (*NIPBL* seq then *SMC1A* seq if negative, then *NIPBL/SMC1A* del/dup by array-CGH if negative)
☐ *NIPBL* Sequencing ☐ *NIPBL* Del/Dup (by MLPA)
☐ *SMC1A* Sequencing ☐ *SMC1A* Del/Dup (by array-CGH)

Crigler-Najjar syndrome testing

☐ *UGT1A1* Sequencing ☐ *UGT1A1* Del/Dup (by array-CGH)

Glucose transporter type 1 deficiency testing

☐ *SLC2A1* Sequencing Only ☐ *SLC2A1* Del/Dup (by MLPA)

MEF2C testing

☐ *MEF2C* Sequencing ☐ *MEF2C* Del/Dup (by array-CGH)

Menkes disease testing

☐ *ATP7A* Sequencing ☐ *ATP7A* Del/Dup (by MLPA)

Microcephalic Osteodysplastic Primordial Dwarfism II/Seckel

☐ *PCNT* Sequencing Only
☐ Seckel Tier 2 Panel (*ATR, CENPJ,* and *CEP152* sequencing)

Mowat-Wilson syndrome testing

☐ *ZEB2* Sequencing ☐ *ZEB2* Del/Dup (by MLPA)

Pitt-Hopkins syndrome testing

☐ *TCF4* Sequencing ☐ *TCF4* Del/Dup (by MLPA)

Rett/Atypical Rett syndrome testing

☐ Rett/Atypical Rett Syndrome Panel (*MECP2, CDKL5, MEF2C* and *FOXG1* sequencing and del/dup by array-CGH)
☐ *MECP2* Sequencing ☐ *MECP2* Del/Dup (by MLPA)
☐ *CDKL5* Sequencing ☐ *CDKL5* Del/Dup (by MLPA)
☐ *FOXG1* Sequencing ☐ *FOXG1* Del/Dup (by MLPA)
☐ *MEF2C* Sequencing ☐ *MEF2C* Del/Dup (by array-CGH)

Early infantile epileptic encephalopathy (EIEE) testing

☐ EIEE Panel A (*ARX* and *CDKL5* sequencing and del/dup by MLPA)
☐ EIEE Panel B (*SLC25A22* and *STXBP1* sequencing)
☐ *ARX* Sequencing ☐ *ARX* Del/Dup (by MLPA)
☐ *CDKL5* Sequencing ☐ *CDKL5* Del/Dup (by MLPA)
☐ *STXBP1* Sequencing ☐ *STXBP1* Del/Dup (by array-CGH)
☐ *SLC25A22* Sequencing Only
☐ *PCDH19* Sequencing Only

Kabuki syndrome testing

☐ *MLL2* Sequencing Only

NBIA testing

☐ *FTL* Sequencing Only
☐ *PANK2* Sequencing ☐ *PANK2* Del/Dup (by MLPA)
☐ *PLA2G6* Sequencing ☐ *PLA2G6* Del/Dup (by MLPA)

Roberts syndrome testing

☐ *ESCO2* Sequencing ☐ *ESCO2* Del/Dup (by array-CGH)

Robinow syndrome testing

☐ *ROR2* Sequencing ☐ *ROR2* Del/Dup (by MLPA)

Rubinstein-Taybi syndrome testing

☐ Rubinstein-Taybi syndrome series (*CREBBP* del/dup then *CREBBP* sequencing if negative)
☐ *CREBBP* Sequencing ☐ *CREBBP* Del/Dup (by MLPA)

Sotos syndrome testing

☐ Sotos syndrome series (*NSD1* sequencing then *NSD1* del/dup if negative)
☐ *NSD1* Sequencing ☐ *NSD1* Del/Dup (by MLPA)

UGT1A1 testing

☐ *UGT1A1* genotyping for Gilbert syndrome
☐ *UGT1A1* genotyping for irinotecan dosing

UPD testing (requires samples from both parents also)

☐ UPD6 ☐ UPD14
☐ UPD7 ☐ UPD15

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Wilson disease testing

☐ *ATP7B* Sequencing ☐ *ATP7B* Del/Dup (by MLPA)

Other Tests

☐ Ashkenazi Jewish *BRCA1/BRCA2*

Hearing Loss

☐ *CX26/GJB2* Sequencing ☐ *CX26/GJB2* Del/Dup (by MLPA)

Charcot-Marie-Tooth disease

☐ *DNM2* Sequencing ☐ *DNM2* Del/Dup (by array-CGH)

Bernard-Soulier syndrome

☐ *GpIbβ* Sequencing ☐ *GpIbβ* Del/Dup (by array-CGH)

Neonatal Diabetes

☐ *KCNJ11* Sequencing ☐ *KCNJ11* Del/Dup (by array-CGH)

Lamin A/C

☐ *LMNA* Sequencing ☐ *LMNA* Del/Dup (by array-CGH)

Isolated Congenital Heart Defects

☐ *NKX2.5* Sequencing Only

CHILD syndrome

☐ *NSDHL* Sequencing ☐ *NSDHL* Del/Dup (by array-CGH)

***OFD1*-Related Disorders**

☐ *OFD1* Sequencing Only ☐ *OFD1* Del/Dup (by array-CGH)

***MCT8* testing**

☐ ***3-10cc blood in an EDTA (purple top) tube and 3-10cc blood in a red top tube***

TIER 1 (*MCT8* thyroid panel)

TIER 2 (*MCT8* sequencing and deletion/duplication) if TIER 1 is consistent with *MCT8*

Custom Mutation Analysis

(testing for a previously detected mutation or sequence change)*.

Gene: _____ Change: _____

***Requires prior approval by UCGS Lab staff if this is a gene for which we do not offer full sequencing**

Deletion/Duplication Analysis by array-CGH

Gene(s): _____

Please note that for deletion/duplication for two or more genes by array-CGH or by array-CGH and MLPA, analysis will be performed utilizing array-CGH. Cost will be $1545 instead of the sum of the list price of each individual deletion/duplication test. If multiple deletion/duplication test requests are individually performed only by MLPA, total cost will be the sum of each individual deletion/duplication test.

BILLING OPTIONS

Samples received without billing information will delay processing time.
Pre-payment is required for samples referred from outside of the US or Canada.
We do not bill insurance for *ASPM, MLL2, NIPBL, NSD1* sequencing, MCPH tier 2 Panel and Seckel Tier 2 Panel.

1. **SELF-PAY:** ☐ Check/Money Order
(Make check payable to: The University of Chicago Genetic Services)
☐ Credit Card (Visa/Mastercard)

We will not be responsible for refunding any "cost differential" that may occur as a result of a patient seeking any type of reimbursement.

Card #: _____ Exp. Date: _____

Cardholder Name: _____

Cardholder Signature: _____
For security purposes, please provide 3-digit code on back of credit card: _____

2. **INSTITUTIONAL BILLING**

Billing Institution: Mayo Medical Laboratories
Financial Contact: _____
Address: PO BOX 4100
City: Rochester State: MN Zip: 55903-4100
E-mail (required): _____
Phone #: 800-447-6424 Fax#: _____

3. **INSURANCE BILLING**
We do NOT accept Illinois or any out-of-state Medicaid.

Please include a copy of the front and back of the insurance card

•Pre-authorization # (if applicable): _____

GUARANTOR NAME: _____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP : _____

PHONE: _____

The policy holder's signature to the following statement: I hereby authorize any physician who treated or attended to me or my dependant(s) to furnish any medical information requested. In consideration of services rendered, I hereby transfer and assign to the University of Chicago Genetic Services any benefits of insurance I may have. I assume responsibility for the balance of the cost of testing not paid by my insurance company within 6 months of the date of service. The total cost of the testing ordered for me or my dependant is $ _____. A photocopy of this authorization shall be considered as effective and valid as original.

Signature: _____ Date: _____

Cornelia de Lange Syndrome Clinical Questionnaire

Please complete and return with sample

Name: _____ **DOB** _____ **Date** _____

Features	Present:	Yes	No
Growth			
IUGR		☐	☐
Failure to Thrive		☐	☐
Gestational Age	_____ wks		
Birth weight	_____ gms		
Birth length	_____ cm		
OFC	_____ cm		
Age at Exam	_____ yrs & mos		
Height	_____ cm		
Weight	_____ kg		
OFC	_____ cm		
Craniofacial			
Microbrachycephaly		☐	☐
Synophrys/arched eyebrows		☐	☐
Long, thick eyelashes		☐	☐
Low-set ears		☐	☐
Posteriorly rotated ears		☐	☐
Thickened helices		☐	☐
Broad nasal bridge		☐	☐
Upturned/anteverted nares		☐	☐
Long, smooth philtrum		☐	☐
Thin upper lip		☐	☐
Downturned corners of mouth		☐	☐
High arched palate		☐	☐
Cleft palate		☐	☐
Small teeth		☐	☐
Widely spaced teeth		☐	☐
Micrognathia		☐	☐
Bluish tinge around eyes or mouth		☐	☐
Low-pitched cry		☐	☐
Short neck		☐	☐
Low posterior hairline		☐	☐
Developmental Delay		☐	☐
Age Sat _____			
Age Walked _____	Verbal IQ		_____
Age Talked _____	Performance IQ		_____
Neurologic Seizures		☐	☐
Limb Abnormalities			
Upper extremity deformity		☐	☐
Describe _____			
Small hands		☐	☐
Proximally placed thumbs		☐	☐
5th finger clinodactyly		☐	☐
Limitation of elbow extension		☐	☐
Lower extremity involvement		☐	☐
Small feet		☐	☐
2-3 toe syndactyly		☐	☐

Features	Present:	Yes	No
Gastrointestinal			
GER		☐	☐
Pyloric stenosis		☐	☐
Intestinal malrotation		☐	☐
Congenital diaphragmatic hernia		☐	☐
Other: _____			
Otolaryngologic			
Sensorineural hearing loss		☐	☐
Ophthalmologic			
Ptosis		☐	☐
Strabismus		☐	☐
Lacrimal duct obstruction		☐	☐
Myopia		☐	☐
Genitourinary			
Cryptorchidism		☐	☐
Hypoplastic genitalia		☐	☐
Renal abnormalities		☐	☐
Cardiovascular		☐	☐
If so, what is the defect? _____			
Dermatologic			
Hirsutism		☐	☐
Cutis marmorata		☐	☐
Hypoplastic nipples		☐	☐
Small umbilicus		☐	☐
Single palmar crease		☐	☐

Additional findings:

Relevant family history:

These data are from CETT-sponsored clinical diagnostic testing (www.CETTProgram.org) and do not require the informed consent of a research participant. As part of clinical care, patients agree to additional use of their HIPAA-compliant data. All patients in this program receive information on opting out of having their de-identified data shared beyond the clinical laboratory.