COLLAGEN DIAGNOSTIC LABORATORY

UW MEDICINE CENTER FOR PRECISION DIAGNOSTICS

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LABORATORY TEST REQUISITION FORM

PATIENT INFORMATION	REPORTING RESULTS

PATIENT INFORMATION

NAME:
DOB:
SEX: ☐ MALE ☐ FEMALE
YOUR PATIENT ID#:
ADDRESS:
CITY: STATE: ZIP:
PHONE:

SAMPLE TYPE:

☐ Blood **(PREFERRED)** 5-7cc, purple top EDTA
☐ DNA (minimum 150µl at ≥200ng/µl or 30µg)
☐ Saliva
☐ Amniocytes (2 T25-flasks, cultured)
☐ CVS Cells (2 T-25 flasks, cultured)
☐ Skin biopsy
☐ Cultured fibroblasts
☐ Stored cells (CDL Repository)

REPORTING RESULTS

REFERRING PHYSICIAN (REQUIRED):
NAME:
NPI #:
PHYSICIAN SPECIALTY:
GENETIC   COUNSELOR:
INSTITUTION:
ADDRESS:
CITY: STATE: ZIP:
COUNTRY:
PHONE:
FAX:
EMAIL:

REFERRING LAB:
SEND OUT COORDINATOR:
ADDRESS:
CITY: STATE: ZIP:
COUNTRY:
PHONE:
FAX:

At CDL, we are committed to excellence in health care, biomedical education and research. To this end we may use submitted clinical information and remaining specimens to better understand disease mechanism, to improve laboratory testing and for educational purposes. De-identified data from tested individuals may be submitted to clinical genetic data registries and/or for publication. Individuals may refuse to allow CDL to use their information and specimen by signing below.   A description of this testing policy and research approach is available at *www.uwcdl.org*

*OPT OUT SIGNATURE*_____*DATE* _____

CLINICAL INFORMATION – PLEASE ATTACH CLINIC NOTE

SUSPECTED DIAGNOSIS:

☐ Osteogenesis Imperfecta   ☐ Ehlers-Danlos Syndrome   ☐ Marfan Syndrome   ☐ Loeys-Dietz Syndrome
☐ Familial Aneurysm Syndrome   ☐ Other:

CLINICAL DESCRIPTION – PLEASE ATTACH CLINIC NOTE:

☐ Blue sclerae	☐ Hearing Loss	☐ High arched palate	☐ Lens dislocation	☐ Dentinogenesis Imperfecta
☐ Translucent skin	☐ Easy bruising	☐ Atrophic scarring	☐ Bifid Uvula	☐ Dural ectasia ☐ Scoliosis
☐ Bone deformity	☐ Short Stature	☐ Joint hypermobility	☐ Joint dislocations	☐ Congenital contractures

☐ Fractures (age and location):
☐ Vascular Event: dissection, aneurysm, rupture (age and location):

☐ Other findings/history:

☐ Positive family history (please include pedigree)

Special Instructions and Additional Information (if prenatal, include EDC):

☐ **Known Mutation/Variant Testing**　　*(Please provide copy of report if testing done at another laboratory)*
　Name of Relative (Proband):　　　　　　　　　　　CDL#:
　Relationship to Proband:　　　　　　　　　　Gene:　　　　　　Mutation/Variant:

	Sequencing	Deletion/Duplication	Seq reflex to Del/Dup
Osteogenesis Imperfecta and genetic bone disorders			
Autosomal Dominant (AD) OI Panel (*COL1A1, COL1A2, IFITM5*)	☐	☐	☐
Autosomal Dominant OI Panel + *PLS3* (*COL1A1, COL1A2, IFITM5, PLS3*)	☐	☐	☐
Autosomal Recessive (AR) OI Panel + *ALPL*	☐	☐	☐
(ALPL, BMP1, CREB3L1, CRTAP, FKBP10, LEPRE1, PLOD2, PPIB, SERPINF1, SERPINH1, SP7, TMEM38B, WNT1)			
Dominant and Recessive OI Panel (17 genes)	☐	☐	☐
Individual Gene(s):			
COL1A1 and *COL1A2*	☐	☐	☐
IFITM5	☐	☐	☐
Autosomal Recessive OI gene: _____	☐	☐	☐
Bruck Syndrome (*FKBP10, PLOD2*)	☐	☐	☐
Caffey Disease (*COL1A1* c.3040C>T)	☐	☐	☐
Hypophosphatasia (*ALPL*)	☐	☐	☐
X-Linked Osteoporosis (*PLS3*)	☐	☐	☐
Ehlers-Danlos Syndromes			
Core Ehlers-Danlos Syndrome Panel (*COL3A1, COL5A1, COL5A2*)	☐	☐	☐
Classical EDS Panel (*COL5A1* and *COL5A2*)	☐	☐	☐
Vascular, type IV (*COL3A1*)	☐	☐	☐
Ocular-scoliotic, type VI (*PLOD1*)	☐	☐	☐
Arthrochalasia, type VII (Exon 6 *COL1A1/2*)	☐	☐	☐
FKBP14-Related Ehlers-Danlos syndrome	☐	☐	☐
Vascular Genetic Disorders			
Core Familial Aneurysm Panel	☐	☐	☐
(ACTA2, COL3A1, TGFBR1, TGFBR2, SMAD3, TGFB2, FBN1, MYH11, MYLK, PRKG1, SLC2A10, TGFB3, MAT2A[(no del/dup)]*, SKI, FBN2*			
Marfan Syndrome and Loeys-Dietz Panel	☐	☐	☐
(FBN1, TGFBR1, TGFBR2, SMAD3, TGFB2, TGFB3)			
Marfan Syndrome (*FBN1*)	☐	☐	☐
Loeys-Dietz syndrome			
TGFBR1 and *TGFBR2*	☐	☐	☐
SMAD3	☐	☐	☐
TGFB2	☐	☐	☐
TGFB3	☐	☐	☐
Familial Thoracic Aortic Aneurysm/Dissection Individual Genes			
ACTA2	☐	☐	☐
MYH11	☐	☐	☐
MYLK	☐	☐	☐
PRKG1	☐	☐	☐
Arterial Tortuosity Syndrome (*SLC2A10*)	☐	☐	☐
COL4A1 and *COL4A2* Related Disorders (*COL4A1* and *COL4A2*)	☐	☐	☐
Alport Syndrome			
Alport Syndrome Panel *(COL4A3, COL4A4, COL4A5)*	☐	☐	☐
X-Linked Alport Syndrome (*COL4A5*)	☐	☐	☐
Maternal Cell Contamination Studies	☐		

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BILLING INFORMATION

Requested laboratory testing will be initiated only AFTER accurate billing information is provided.

Canadian samples: Providers must acquire approval of all tests, including reflex testing, before submitting samples.

BILL INSURANCE: <u>PATIENT INSURANCE</u>

☐ Hold testing pending insurance pre-authorization (submit CPDx Insurance Verification form as needed)

☐ Proceed with testing (includes insurance where no authorization is required)

Please attach a copy of card for all insurance billing

Name on Policy:

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other (please specify):

Cardholder DOB: Dates of Coverage:

Patient Policy ID#:

Group Name: Group #:

Insurance Co. Name:

Claims Billing Address:

BILL PATIENT: <u>SELF-PAY or INTERNATIONAL SAMPLES</u>

☐ Check *(payable to UW Physicians)* or Money Order

Amount (USD):   (Amount authorized to be charged)

Card type: ☐ Visa ☐ MC ☐ AmEx ☐ Discover

Card #:   Exp. Date: CVV#:

Name of cardholder:

Cardholder date of birth:

Billing address:

☐ Electronic Funds Transfer (EFT) (See website for details)

EFT Amount: USD

BILL MEDICAID:

For Medicaid billing, the following is <u>required</u>:

- ❑ Medicaid claims address
- ❑ Copy of card
- ❑ Letter of necessity from referring physician

For questions regarding Medicaid or Medicare, please consult our website at www.uwcdl.org

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BILL INSTITUTION: <u>INSTITUTIONAL BILLING</u>

Institution Name:

Tax ID Number: PO#:

Claims Billing Address:

City: State: ZIP:

Billing Contact Name:

Phone: Fax:

Send Result Report: ☐

SHIP SAMPLE OVERNIGHT TO:

Peter H. Byers, MD

UW Medicine Center for Precision Diagnostics

Lab H-561, Health Science Bldg.

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Seattle, WA 98195