COLLAGEN DIAGNOSTIC LABORATORY

UW MEDICINE CENTER FOR PRECISION DIAGNOSTICS
Peter H. Byers, MD, University of Washington, Lab H-561 Health Sciences, 1959 NE Pacific St, Seattle, WA 98195
Main Phone (206) 543-0459; Genetic Counselors (206) 543-5464; ***Fax (206) 616-1899; www.uwcdl.org***

LABORATORY TEST REQUISITION FORM

PATIENT INFORMATION

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

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:

SAMPLE TYPE:

☐ Blood **(PREFERRED)** 5-7cc, purple top EDTA
☐ DNA (minimum 5μg)
☐ Saliva
☐ Amniocytes (2 T25-flasks, cultured)
☐ CVS Cells (2 T-25 flasks, cultured)
☐ Cultured fibroblasts
☐ Stored cells (CDL Repository)

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):

TEST REQUESTED (*See website for current costs and CPT codes)*

☐ **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)*	☐	☐	☐
Comprehensive Dominant OI Panel *(COL1A1, COL1A2, IFITM5, PLS3, P4HB*, LRP5*, WNT1, ALPL)*	☐	☐	☐
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			
Comprehensive EDS Panel *(COL5A1, COL5A2, COL3A1, FLNA, PLOD1, COL1A1, COL1A2, ADAMTS2, C1S*, C1R*, ATP7A, CHST14, FKBPBP14, SLC39A13)*	☐	☐	☐
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*)	☐	☐	☐
Periodontal, type VIII (*C1S* and *C1R*)	☐	☐	☐
FKBP14-Related Ehlers-Danlos syndrome	☐	☐	☐
Vascular Genetic Disorders			
Arterial Aneurysm Panel *(ACTA2, COL3A1, FBN1, FBN2, MAT2A*, MYH11, MYLK, PRKG1, SKI, SLC2A10, SMAD3, TGFB2, TGFB3, TGFBR1, TGFBR2, FOXE3, BGN*, LOX*, MFAP5*, PLOD3*, SMAD2*, SMAD4*, CBS*)*	☐	☐	☐
Marfan Syndrome and Loeys-Dietz Panel *(FBN1, TGFBR1, TGFBR2, SMAD2, SMAD3, SMAD4, TGFB2, TGFB3)*	☐	☐	☐
Marfan Syndrome (*FBN1*)	☐	☐	☐
Loeys-Dietz Syndrome Individual Genes Choose: ☐ *TGFBR1* and *TGFBR2* ☐ *SMAD3* ☐ *TGFB2* ☐ *TGFB3*	☐	☐	☐
Familial Thoracic Aortic Aneurysm/Dissection Individual Genes Choose: ☐ *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	☐		

*Deletion/duplication studies unavailable for this gene

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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: PATIENT INSURANCE

☐ Hold testing pending pre-authorization (submit CPDx Insurance Verification form; no pre-auth for tests <$500)

☐ 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: SELF-PAY or INTERNATIONAL SAMPLES

☐ 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 required:

- 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

BILL INSTITUTION: INSTITUTIONAL BILLING

Institution Name:
Tax ID Number: PO#:
Claims Billing Address:
City: State: ZIP:
Billing Contact Name:
Phone: Fax:
Send Result Report: ☐

DATE FORM COMPLETED:_____/_____/_____

SHIP SAMPLE OVERNIGHT TO:
Peter H. Byers, MD
UW Medicine Center for Precision Diagnostics
Lab H-561, Health Science Bldg.
1959 NE Pacific Street
Seattle, WA 98195