Test Requisition Form

PerkinElmer
For the Better

Patient Information:

Name:_____ Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Address:_____ Medical Record #: _____ **FILTER PAPER # :** _____

_____ Daytime Telephone #: (____) _____-_____

Date Sample Collected:_____/____/_____ Hospital/Lab ID #: _____ Submitter #: _____

Date Sample Mailed: ____/____/_____ Form Completed By: _____ Telephone #: (_____) _____-_____

Testing Ordered (please check)

Newborn Metabolic Screens:

- ☐ Comprehensive Newborn $199.00
  - ☐ Expedited Processing & Resulting $100.00

Post Mortem Screens:

- ☐ Blood (Filter Paper Spot) $ 50.00
- ☐ Vitreous Fluid (Filter Paper Spot) $115.00
- ☐ Bile (Filter Paper Spot) $115.00
- ☐ Liver Tissue Blot* $115.00

Specialty Testing:

- ☐ PKU Confirmatory Testing $ 50.00
- ☐ PKU Clinical Monitoring $ 50.00
- ☐ PKU Cofactor Screen (Pterins, DHPR) $140.00
  - ☐ Pterins only, urine spot $120.00
  - ☐ DHPR only, blood spot $ 45.00
- ☐ Succinylacetone (SUAC) $ 50.00
- ☐ Galactosemia Monitoring $ 50.00

DNA Screens:

- ☐ Biotinidase $175.00
- ☐ Cystic Fibrosis $195.00
- ☐ Galactosemia $175.00
- ☐ G6PD $155.00
- ☐ Glutaric Acidemia Type 1 $135.00
- ☐ Hemoglobinopathies $185.00
  - Hb S, Hb C, Hb E, HbD & HbO
  - 3 mutations for B-Thal
  - ☐ Sickle Cell Anemia Panel $125.00
  - ☐ Thalassemia Panel $100.00
- ☐ IVA $135.00
- ☐ LCHAD $135.00
- ☐ MCAD $135.00
- ☐ MCC $135.00
- ☐ MMA/PPA $175.00

DNA Screens: (continued)

- ☐ MSUD $135.00
- ☐ SoundGene (including CMV) $198.00

Combined Acylcarnitine Profile (fatty & organic acids) & Amino Acid Profiles using Tandem Mass Spectrometry includes Free & Total Carnitine:

- ☐ Blood (Filter Paper Spot) $ 61.50
- ☐ Plasma (Filter Paper Spot) $ 61.50
- ☐ Plasma (Liquid)** $ 90.00
- ☐ CSF (Liquid)** $115.00
- ☐ Urine (Liquid)** $115.00

***Please call for Sample Preparation Instructions.**

****All liquids should be frozen and sent overnight.**

List of Current Medications: _____

Relevant Lab Tests: _____

Suspected Diagnosis: _____

Special Instructions: _____

Ethnic Background (DNA Screens only)
(Required for Interpretation)

- ☐ N. European Caucasian
- ☐ S. European Caucasian
- ☐ Hispanic
- ☐ Ashkenazi Jewish
- ☐ African American
- ☐ Sephardic Jewish
- ☐ Other, Please Specify

_____

_____

Family History
(Required for Interpretation)

Indication(s) for Screening
(DNA Screens only)

Routine Carrier Studies
Is Patient Pregnant?_____
If yes, _____ weeks Gestation

- ☐ Ova/Sperm Donor
- ☐ Suspected Diagnosis

Requesting Physician Information

Physician Name: _____

Physician Address: _____

_____

Physician's Signature:_____

Physician's Phone: (_____) _____ - _____

Physician's FAX: (_____) _____ - _____

- ☐ Invoice Physician/Facility at above address
- ☐ Prepayment by Patient via Credit Card, Check or Money Order Payable to PerkinElmer Genetics

Relevant Clinical Information:

_____

_____

Billing Contact & Address:_____

_____

_____

Mailing/Courier Address: **PerkinElmer Genetics, Inc.**
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Bridgeville, PA 15017
Telephone 1-866-463-6436 FAX 412-220-0784

www.perkinelmergenetics.com