



OHSU Molecular Diagnostic Center

Phone: 503-494-5400 Fax: 503-494-6922

Shipping: 2525 S.W. 3rd Avenue, Suite 350, Portland, OR 97201

Genetics Testing Requisition

Sample Collection Date: Time: \*ICD9 code(s):

PATIENT INFORMATION:

Last Name: First Name: Middle:
Female Male Birthdate: SS#:
Address: Home Phone#:
City State Zip Code

CLIENT INFORMATION:

Referring MD: NPI#:
Office Address:
Phone: FAX: Email
Referring Laboratory: Lab Reference #
Address:
City State Zip Code Phone: FAX:
Fax Report: Yes No Telephone result: Yes No

Indication(s) for Testing:

- Symptomatic Family History:
Carrier Screening Diagnostic Testing of Fetus
General Population Screening
Other (specify)
Pregnancy: LMP: GA:

ETHNICITY

- CAUCASIAN/ NON-HISPANIC
AFRICAN AMERICAN
OTHER JEWISH
ASHKENAZI JEWISH
HISPANIC AMERICAN
NATIVE AMERICAN INDIAN
ASIAN
OTHER:

Specimen Type:

- Peripheral Blood Cultured Amniocytes
Amniotic Fluid, Direct Other

INCLUDE A PEDIGREE IN THE SPACE BELOW

FAMILY HISTORY/PEDIGREE
Identify this patient with an arrow.

Test(s) Requested: For prenatal and custom sequencing, please call the lab prior to sending samples.

- Angelman Syndrome Methylation
CPT1A
CF Screening
CF Sequencing
DNA Storage
Duchenne/Becker Muscular Dystrophy:
Male Proband
Female Carrier
Female Proband
Fanconi Anemia A (FANC-A)
Fanconi Anemia C (FANC-C)
Fanconi Anemia E (FANC-E)
Fanconi Anemia F (FANC-F)
Fanconi Anemia G (FANC-G)
Factor V (Leiden)
Fetal Sex Determination
Fragile X Syndrome
FRAXE Syndrome
Hemochromatosis:
C282Y
H63D
Huntington Disease (HD)
Infantile Neuroaxonal Dystrophy
Maternal Cell Rule Out
Mitochondrial Studies:
MELAS
MERRF
NARP
Southern Analysis:
Deletion/ Duplication
MSI
MTHFR
Myotonic Dystrophy (DM)
Noonan Syndrome
PKAN
Prader-Willi Syndrome
Prothrombin
Rett Syndrome
Sequencing, Custom:
Zygoty Testing
Other

Billing Information: Bill (check one): APPROPRIATE AREAS MUST BE COMPLETED OR REFERRING LAB/PHYSICIAN WILL BE BILLED.

- Referring Lab/Industrial Account
Patient
Subscriber (if other than patient): Date of Birth SS#
Insurance Company: Policy#: Group#:
Billing Address: City State Zip Code Phone#
Medicare—Policy #: Primary or Secondary (if secondary, provide Insurance Info.)
Medicaid—Policy #: State: Preauthorization #:
International Studies require payment to accompany sample. Send money order/check in US funds or provide credit card information:
Credit Card Company: (Cards accepted: VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, JCB)
Account #: Security Code (On Back of Card) Exp Date: Name of Card Holder: