



Technical Supervisor: Andrea E. DeBarber, PhD
 Email: debarber@ohsu.edu
 Director/Clinical Consultant: P. Bart Duell, MD

Sterol Analysis Laboratory
 Oregon Health & Science University
 3181 SW Sam Jackson Park Road
 Portland, OR 97239
 Laboratory Phone: 503-494-4593
 CAP # 2442607

CLIA # 38D06-56829

Form Title: Sterol Analysis Laboratory Test Requisition Form

| Patient Information | | | | |
|--|--|---|-----|--------------------------------------|
| Patient Last name | First name | MI | Sex | DOB (MM/DD/YY) ____ / ____ / ____ |
| Dx Code | Collection Date (MM/DD/YY) ____ / ____ / ____ | Ordering Physician: Name (printed) | | |
| Patient ID # | Time (use 24 hour clock) ____ : ____ | | | |
| Is this a known affected patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which disease? _____ | | Signature* (required) *By signing the physician attests that they have provided a detailed explanation of the risks, benefits and limitations of the requested testing to the patient/parent/guardian. It is the physician's responsibility, prior to ordering any test, to obtain consent for testing from the patient (or authorized representative) as required by applicable state law and/or regulations. | | |
| Patient Medications: | | | | |

| Reporting and Billing | |
|------------------------------|--------------------|
| Send Bill To:* | Send Report To: |
| Referring Laboratory/Patient | Ordering Physician |
| Address | Address |
| State, Zip Code | State, Zip Code |
| Phone | Phone |
| Fax | Fax |
| Contact Person Name | Physician Email |
| Contact Person Email | Additional Email |

*Billing is to the Referring Laboratory or Patient. To bill to insurance please request OHSU sample requisition form, also found here:
<https://www.ohsu.edu/sites/default/files/2023-04/Laboratory%20Requisition%2004-11-23.pdf>

Shipping: Specimens should be shipped by overnight express carrier Monday through Thursday. Saturday, Sunday and holiday deliveries are not possible. Please contact us and provide a tracking number for the shipment. Whole blood specimens should be shipped with an "ice pack" (**do not freeze**). Plasma/serum specimens should be shipped frozen on dry ice. Urine can be shipped with "ice pack" or frozen.

Ship to: Attention: Andrea DeBarber (tel: 503-494-4593, email: debarber@ohsu.edu)
 Mailcode L469B
 RJH Room 3360, Dock 4, Oregon Health & Science University
 3181 SW Sam Jackson Park Road
 Portland, OR 97239-3098



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| Test Ordering Selection | | | | | |
|--|----------|--|--|-------|--------------------------|
| Blood Testing for Sitosterolemia/Phytosterolemia | CPT Code | Sample Types and Amounts | | Cost | Check Test(s): |
| Plasma Sitosterol | 82542 | Plasma -1 mL EDTA/Heparin or Whole blood 3 mL EDTA/Heparin | | \$255 | <input type="checkbox"/> |
| Blood Testing for Smith-Lemli-Opitz Syndrome/SLOS/RSH | CPT Code | Sample Types and Amounts | | Cost | Check Test(s): |
| Plasma 7-Dydrocholesterol | 82542 | Plasma -1 mL EDTA/Heparin or Whole blood 3 mL EDTA/Heparin | | \$255 | <input type="checkbox"/> |
| Blood and Urine Testing for Cerebrotendinous Xanthomatosis/CTX | CPT Code | Sample Types and Amounts | | Cost | Check Test(s): |
| Plasma/Serum Cholestanol | 82542 | Plasma -1 mL EDTA/Heparin or Whole blood 3 mL EDTA/Heparin | | \$255 | <input type="checkbox"/> |
| Plasma/Serum 7 α -Hydroxy-4-cholesten-3-one and 7 α ,12 α -Dihydroxy-4-cholesten-3-one | 82542 | | | \$295 | <input type="checkbox"/> |
| Plasma/Serum Bile Alcohol (5 β -Cholestane-3 α ,7 α ,12 α ,25-tetrol Glucuronide) | 82542 | | | \$290 | <input type="checkbox"/> |
| Urine Bile Alcohol (5 β -Cholestane-3 α ,7 α ,12 α ,23S,25-pentol) | 82542 | Random Urine - 5 mL No Preservative | | \$235 | <input type="checkbox"/> |
| Blood and Urine Testing for Neimann-Pick disease Type-C/NPC | CPT Code | Sample Types and Amounts | | Cost | Check Test(s): |
| Plasma/Serum 7-Ketocholesterol and Cholestan-3 β ,5 α ,6 β -triol | 82542 | Plasma -1 mL EDTA/Heparin or Whole blood 3 mL EDTA/Heparin | | \$295 | <input type="checkbox"/> |
| Urine 7-Ketocholesterol | 82542 | Random Urine - 5 mL No Preservative | | \$290 | <input type="checkbox"/> |

| To be completed by Sterol Analysis Laboratory staff: | |
|--|------------------|
| Received by: _____ | Date: _____ |
| Sample arrived under acceptable conditions and within stability window. <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Specimen Type: _____ | Sample ID: _____ |
| Specimen Type: _____ | Sample ID: _____ |
| Sample ID example: STAN_YYMMDD_00X. The date the sample is received (YYMMDD) and order of receipt (001, 002, etc.) | |