

PATIENT INFORMATION

PATIENT D.O.B. _____

PATIENT LAST NAME _____ FIRST NAME _____ MI _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX: M F _____

DUKE HISTORY # _____

PATIENT TELEPHONE #: _____

REQUESTING INSTITUTION PATIENT ID CODE: _____

***The DUHS Molecular Diagnostics Laboratory does not bill patients or their insurance companies. The submitting physician/institution is charged for all non-Duke patient testing.

INDICATION

Indications for Study or ICD9 Code: (REQUIRED)

REQUIRED: Ethnicity of Patient: Other: _____

African-American Asian-American European-Caucasian
 Hispanic-Caucasian Ashkenazi-Jewish

SPECIMEN COLLECTION

COLLECTION DATE ____/____/____ TIME: _____

SPECIMEN TYPE* :

Bone Marrow Peripheral Blood
 Buccal Swab Fresh Tissue
 Paraffin Block*** Other: _____

***For archival paraffin-embedded tissue, please provide the Surgical Pathology case number as well as the block number to be tested:
 S____-____-____ block _____

- Blood and bone marrow: purple top EDTA tubes; 3-6mls for most tests.
- Fresh tissue: freeze if not arriving in the lab within 4 hours of collection
- Samples should arrive in the lab within 24 hours of collection and may be transported at room temperature.
- Buccal swab collection kits are available from the lab (919-684-2698).

MOLECULAR NGS PANELS

Colon Hotspot NGS Panel
 Lung Hotspot NGS Panel
 Melanoma Hotspot NGS Panel
 Solid Tumor Hotspot NGS Panel
 Glycogen Storage Disease NGS Panel
 Myeloid NGS Panel*

MOLECULAR MICROBIOLOGY

Human Papillomavirus (HPV)
 [cervical samples in Cytoc PreservCyt solution only]
 Reflex to HPV 16/18 Genotyping

Epstein-Barr Virus (EBV Quantitative PCR) [blood and bone marrow only]
 CMV Genotyping [EDTA plasma]

HCV Genotyping [serum or EDTA plasma]

CLIENT INFORMATION

PHYSICIAN NAME AND ADDRESS: (Results will be sent to this address)

 REQUESTING PHYSICIAN (PLEASE PRINT)

 REQUESTING PHYSICIAN SIGNATURE (REQUIRED)

 STREET ADDRESS

 CITY _____ STATE _____ ZIP _____
 TELEPHONE # _____ FAX # _____
 EMAIL _____

BILLING CONTACT NAME AND ADDRESS: (Required)

INSTITUTION / CONTACT PERSON

 STREET ADDRESS

 CITY _____ STATE _____ ZIP _____
 TELEPHONE # _____ FAX # _____

MOLECULAR ONCOLOGY

B Cell Clonality/ Gene Rearrangement (B Cell IgH/IgKappa Chain PCR)
 T Cell Clonality/ Gene Rearrangement (T Cell Gamma/Beta Chain PCR)
 IGH Somatic Mutation Analysis
 BCR/ABL1 t(9;22) Quantitative PCR
 ABL1 Kinase Domain Sequencing
 JAK2 V617F Mutation Analysis
 CALR Mutation Analysis
 NPM1 Targeted Mutation Analysis
 CEBPA Targeted Mutation Analysis
 IDH1 Targeted Mutation Analysis with reflex to IDH2
 TERT Targeted Mutation Analysis
 KRAS Targeted Mutation Analysis
 BRAF V600E Mutation Analysis with reflex to V600K for melanoma cases
 Microsatellite Instability (MSI) by PCR
 MLH1 Promoter Methylation
 KIT Targeted Mutation Analysis for GIST or melanoma
 PDGFRA Mutation Analysis
 TP53 Gene Sequencing
 EGFR Targeted Mutation Analysis
 Bone Marrow Engraftment Analysis (BME) via STR Profiling
 BME - Pre-Transplant Recipient Sample
 Donor: _____
 BME - Donor Sample
 BME -Post Transplant
 Whole CD3+ CD15+

MOLECULAR GENETICS

Apolipoprotein E (ApoE) Genotyping DNA Extraction and Storage G6PC Sequencing (GSD Ia)
 Cystic Fibrosis (CFTR Targeted Mutation Analysis) TMPRSS6 Sequencing (IRIDA) SLC37A4 Sequencing (GSD Ib)
 Include 5/7/9T IVS-8 Analysis TP53 Sequencing (Li-Fraumeni) GAA Sequencing (Pompe/GSD II)
 Fragile X (FMR1 Triplet Repeat Analysis) MYH9 Sequencing AGL Sequencing (GSD III)
 Hemochromatosis (HFE Targeted Mutation Analysis) MOCS1 Sequencing (Molybdenum cofactor deficiency) GBE1 Sequencing (GSD IV)
 Prader-Willi/Angelman Syndrome Methylation PCR MOCS2 Sequencing (Molybdenum cofactor deficiency) PHKA2 Sequencing (GSD IXa/XLG)
 Interleukin 28B (IL28B) Genotyping SUOX Sequencing (Sulfite oxidase deficiency) PHKG2 Sequencing (GSD IXc)
 UDP-Glucuronosyltransferase (UGT1A1) Genotyping GLA Sequencing (Fabry)
 ACE Polymorphism Analysis