Molecular Diagnostics Hereditary Sequencing Request Form http://www.dukemolecular.org

DUKE UNIVERSITY HEALTH SYSTEM • PHONE: (919) 684-2698 • FAX: (919) 668-9173
DUHS Clinical Labs • 2351 Erwin Rd. • Room 0220 Wadsworth Bldg • Durham, NC 27705

PATIENT INFORMATION / DEMOGRAPHICS

_____
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: _____

PLEASE PROVIDE NAMES OF OTHER FAMILY MEMBERS BEING TESTED OR TESTED POSITIVE PREVIOUSLY

_____
NAME RELATIONSHIP

RESULTS (Including known mutations): _____

_____
NAME RELATIONSHIP

RESULTS (Including known mutations): _____

_____
NAME RELATIONSHIP

RESULTS (Including known mutations): _____

CLINICAL INFORMATION

ICD-9 CODE (Required):_____

INDICATION FOR TESTING / CLINICAL FINDINGS (Required):

_____

ENZYME TESTING: ☐ CONCURRENT ☐ PREVIOUS
(if applicable)

PERFORMING LAB: _____

ENZYME: _____

RESULTS: _____

SPECIMEN COLLECTION

SPECIMEN REQUIREMENTS:
PERIPHERAL BLOOD: 5cc (1-2cc for infants) in EDTA (purple-top tube)
CULTURED CELLS: T25 flask (80-90% confluent)
Please call the laboratory for requirements for other specimen types.
****Prenatal specimens must be accompanied by a maternal blood sample to rule out maternal cell contamination. Please call the laboratory for all prenatal samples**

COLLECTION DATE:_____/_____/_____

SPECIMEN TYPE:

☐ Peripheral Blood
☐ Skin biopsy (culturing fees apply)
☐ Cultured fibroblasts
☐ Amniotic fluid (culturing fees apply)
☐ Cultured amniocytes / cultured chorionic villi
☐ Extracted DNA**** Concentration: _____
☐ **OTHER (specify):**_____

****If submitting extracted DNA, please include CLIA number of lab that performed the extraction. DNA cannot be accepted from laboratories that are not CLIA-accredited.

BILLING / REPORTING 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

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.

BILLING CONTACT NAME AND ADDRESS: (Required)

_____
INSTITUTION / CONTACT PERSON

_____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP

_____ _____
TELEPHONE # FAX #

TESTS REQUESTED

Please note that informed consent is required for all genetic testing (to be obtained by the ordering physician)

☐ SLC37A4 SEQUENCING (Glycogen storage disease Ib)
☐ GAA SEQUENCING (Pompe, Glycogen storage disease II)
☐ AGL SEQUENCING (Glycogen storage disease III)
☐ PHKA2 SEQUENCING (Glycogen storage disease IXa, XLG)
☐ PHKG2 SEQUENCING (Glycogen storage disease IXc)
☐ GLA SEQUENCING (Fabry disease)
☐ TMPRSS6 SEQUENCING (IRIDA)
☐ TP53 SEQUENCING (Li-Fraumeni Syndrome)
☐ MYH9 SEQUENCING
☐ MOCS1 SEQUENCING (Molybdenum cofactor deficiency)
☐ MOCS2 SEQUENCING (Molybdenum cofactor deficiency)
☐ SUOX SEQUENCING (Isolated sulfite oxidase deficiency)
☐ ALPL SEQUENCING (Hypophosphatasia (HPP))
☐ IDUA SEQUENCING (Mucopolysaccharidosis I (MPS-1))
☐ ABCD1 SEQUENCING (X-linked Adrenoleukodystrophy (X-ALD))

✱For the above tests please indicate one of the following:

☐ FULL GENE (all coding exons)
☐ ONE EXON: _____
☐ TWO EXONS: _____ and _____

SHIPPING INFORMATION

Samples being concurrently tested for enzyme activity by the Duke Biochemical Genetics Laboratory will be shared between the two laboratories. Samples should be shipped via overnight courier to:

Duke Pediatric Biochemical Genetics Laboratory
801 Capitola Drive, Suite 6
Durham, NC 27713
919-549-0445 (phone) / 919-549-0709 (fax)

Samples for genetic sequencing only should be sent to the address on the top of this form.