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)

☐ GAA SEQUENCING (Pompe, Glycogen storage disease II)
☐ AGL SEQUENCING (Glycogen storage disease III)
☐ DPYD SEQUENCING
☐ GLA SEQUENCING (Fabry disease)
☐ TMPRSS6 SEQUENCING (IRIDA)
☐ TP53 SEQUENCING (Li-Fraumeni Syndrome)
☐ MYH9 SEQUENCING
☐ ALPL SEQUENCING (Hypophosphatasia (HPP))
☐ IDUA SEQUENCING (Mucopolysaccharidosis I (MPS-1))

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

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

☐ Germline Confirmation of Familial Variant(s) ***
Gene (transcript) ________________
Coding nucleotide change ________________
Protein change ________________

*****DNA from a known carrier (family member) is required for use as a positive control for this test. No additional fees apply for this specimen.**

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.