Diagnostic Genomics Laboratory (DGL)

Indiana University School of Medicine
Department of Medical and Molecular Genetics
975 W. Walnut St., IB 350
Indianapolis, IN. 46202
Tel: 317-278-0100 Fax: 317-278-0136

Affix label here

SHIP SPECIMENS TO:
975 W. Walnut St., IB 410, Indianapolis, IN 46202

PATIENT INFO

NAME: _____
HOSPITAL: _____
MRN: _____

MALE ☐ FEMALE ☐ DOB: _____

HEALTHCARE PROVIDER

Physician: _____
Genetic Counselor: _____
Address: _____
_____
City, State, Zip: _____
Phone/Fax: _____

SAMPLE INFO

Date Collected: _____
Collected By: _____ Volume: _____

Specimen Type: ☐ Blood (EDTA) ☐ Buccal Swab
☐ Saliva ☐ DNA (Source: _____)
☐ Product of Conception (POC) ☐ Other: _____

CLINICAL INFO

NOTE: Detailed medical records must be attached

Diagnosis/ICD-10: _____
_____

Test for: ☐ rGS - Rapid Genome Sequencing - Trio

NOTE: ***Please provide biological parents information on next page.***

_____

BILLING INFORMATION

Bill to: ☐ Client ☐ Patient (Insurance/Medicare/Medicaid)
☐ Grant (Account #) _____ :
Demographic sheet must be attached.
Please provide a copy of both the front and back of insurance card(s).

Medicare No.	Medicaid No.

Primary Insurance

Primary Insurance	Primary Ins. No.
Group Name	Group No.
Address	
Insured Name	Relationship

Secondary Insurance

Secondary Insurance	Secondary Ins. No.
Group Name	Group No.
Address	
Insured Name	Relationship

LAB USE

Date Received _____ Received By: _____

	NEXT GENERATION SEQUENCING (NGS) TEST ***NOTE: SIGNED INFORMED CONSENT PROVIDED AT THE END OF THIS REQUISITION FORM IS REQUIRED***
	rGS - Rapid Genome Sequencing - Trio (TAT: 5-14 days) ***Additional Reporting Options:*** ☐ **Yes** ☐ **NO** **Report ACMG secondary findings (Only Pathogenic and Likely Pathogenic Variants).** ***NOTE:*** *Parental samples are required for Rapid Genome - Trio testing. Parental Samples could be sent separately and must be received within 3 months of the proband sample.*

Comment(s)/Additional Information

(SPECIMEN REQUIREMENTS, SHIPPING INSTRUCTIONS AND CANCELLATION POLICY AT THE END OF FORM)

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Proband Name:_____

DOB: MM / DD /YYYY

BIOLOGICAL PARENT INFORMATION

Parental samples are required for Trio testing. Parental samples should be labeled with parental full name and date of birth - DO NOT LABEL WITH CHILD'S NAME. Parent(s) must sign the parental testing authorization in the consent section.

Mother

First Name:_____ **Last Name:**_____ **MI:**_____ **DOB:** MM / DD /YYYY

Clinical Information: ☐ Asymptomatic ☐ Symptomatic (attach summary of findings)

Specimen Type: ☐ Blood (EDTA) ☐ Buccal Swab ☐ Saliva ☐ DNA (Source:_____) ☐ Other:_____

Additional Information/Comment(s):_____

_____

Father

First Name:_____ **Last Name:**_____ **MI:**_____ **DOB:** MM / DD /YYYY

Clinical Information: ☐ Asymptomatic ☐ Symptomatic (attach summary of findings)

Specimen Type: ☐ Blood (EDTA) ☐ Buccal Swab ☐ Saliva ☐ DNA (Source:_____) ☐ Other:_____

Additional Information/Comment(s):_____

_____

TRANSFUSION INFORMATION

- Has the patient been transfused within the last 14 days? ☐ Yes ☐ NO
  - Type of transfusion: _____
  - Date of transfusion: MM / DD /YYYY
  - Additional details: _____

PATIENT CONFIDENTIALITY

Federal laws prohibit unauthorized disclosure of test results. To maintain confidentiality, test results will only be released to the referring healthcare provider, the ordering laboratory/hospital, patient/legal guardian, individuals allowed access to test results by law, and to individuals authorized in writing.

GENETIC COUNSELING (EXOME AND GENOME ONLY)

Given the complexity of the exome analysis, **genetic counseling and informed consent by a trained medical geneticist or genetic counselor is recommended prior to and after undergoing this testing**. Informed consent is a process that provides education about genetics, and the options, benefits, limitations, and consequences of genetic testing. Genetic counseling provides the patient with informed consent prior to the decision to undergo testing and with the opportunity to review the results of the test in detail.

CANCELLATION POLICY

Cancellation of test orders must be received within 48 hours of sample receipt in the laboratory.
To cancel testing, call (317) 278-0100.

NOTE: A handling fee may be assessed for initial processing of the sample prior to test cancellation.

To revise requested testing, call (317) 278-0100 to determine the patient sample's status in the laboratory and discuss available options.

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SPECIMEN REQUIREMENTS AND SHIPPING INSTRUCTIONS	
Whole Blood	3-5 ml (2 yrs-adult), 2-3 ml (newborn-2 yrs) in EDTA (purple-top) tube. Attach clinical notes and concurrent laboratory reports Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 24-48 hours of collection.
Buccal Swab	Collect with ORAcollect•Dx (OCD-100) self-collection kit. We highly recommend the sample be collected by a healthcare professional **IMPORTANT**: No eating, drinking, smoking or chewing gum 30 minutes prior to collection. Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze. Sample must arrive within 72 hrs.
Saliva	Collect with Oragene DNA Self-Collection Kit. **IMPORTANT**: No eating, drinking, smoking or chewing gum 30 minutes prior to collection. Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.
DNA	Send at least 25 µg with a minimum average concentration of 50 ng/µL. Extracted DNA will only be accepted if the isolation of nucleic acids for clinical testing occurs in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS. Ship at room temperature in an insulated container by overnight courier. May also be shipped frozen on a minimum of 10 lbs of dry ice in an insulated container by overnight courier.
Products of Conception (POC)	5-10 mm3 Villi from the placenta is the preferred sample type. Fetal cartilage, membranes, and tendon will also be accepted. Transport media will be provided upon request by calling the lab. If not available, use a sterile screw-top container with sterile media. **Refrigerate. Do not send entire fetus.**
Amniotic Fluid	20-25 mL of fluid at 16 weeks or more of gestation (30 mL if additional studies are ordered). Discard first 2-3 mL to avoid maternal cell contamination. Place remaining fluid in 3-4 aliquots, labeled 1st, 2nd, etc. Sterile Corning centrifuge tubes can be provided upon request. For bloody specimens, use Dark Green-top sodium heparin tubes. These tubes are also available upon request by calling the lab. **Refrigerate. Do not centrifuge.**
Chorionic Villus (CVS)	20-30 mg (50 mg if additional studies are ordered). Transport media will be provided upon request by calling the lab. **Refrigerate.**

- Please use sterile technique and close all containers tightly.
- Please label all containers with patient name, hospital number, and date of collection.
- Please attach a completed requisition form, including diagnosis with the sample.
- IU Medical Center campus samples should be delivered to the laboratory on the same day of sample collection. If the sample is collected after business hours or missed the transportation pick-up time, please keep the sample in the refrigerator or at room temp and deliver to laboratory as soon as possible the next business day.
- Samples from off site should be shipped at room temperature for overnight delivery directly to the laboratory's address listed at the top front of this requisition form.
- Grossly hemolyzed or clotted blood specimens will be rejected.