



JOHNS HOPKINS DNA Diagnostic Lab
Test Requisition Part I of II

Shipping Address:
 600 N. Wolfe St
 CMSC 10-106
 Baltimore, MD 21287

Referrer Information

Physician		UPIN #	
Genetic Counselor		Contact Email:	
Institution			
Address City/State/Zip			
Phone		Fax	

I would like results faxed automatically

Additional Reports to

Name /Institution	
Address City/State/Zip	
Phone	Fax

Patient Information

*Two of these identifiers must appear on the sample

*Name (Last)		(First)	
Address City/State/Zip			
*Date of Birth (mm/dd/yyyy)	Ethnicity	Sex	Position in Pedigree
*Patient ID / Sample Number			

Sample Type

Date Collected: _____

- Venous Blood Cord Blood Cleaned Chorionic Villi
 Cultured Amniocytes Cultured Chorionic Villi Cultured Fibroblasts Other Culture _____
 Frozen tissue (source: _____) DNA (source: _____)

Reason for Test

- Prenatal Mutation Identification Family member for Linkage analysis
 Carrier Presymptomatic Confirmatory/Diagnostic

Diagnosis Code (ICD-9): _____ If the patient is pregnant: LMP _____

Billing Information

- Credit Card Type _____ Card Number _____
 Expiration Date _____ Cardholder Name _____
 Check (Check # _____ Amount of Check: \$ _____)
 Patient Insurance **Contact Billing Coordinator at 443-287-2486 prior to submitting.**
 Referring Center (Include address and contact person if different from that provided above)
 Maryland Medicaid # _____ (referral required)
 Medicare # _____ (waiver form required)

For Internal Use Only			
Accession #		Date Received	ID #
Test 1:	Fee 1:	Test 2:	Fee 2:
Notes:			



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Test Requisition Part II of II**

Shipping Address:
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CMSC 10-106
Baltimore, MD 21287

Patient Name: _____

Patient DOB: _____

Test Requested:			Check here <input type="checkbox"/> if ordering a targeted test for a known mutation*		
<p>CRANIOFACIAL DISORDERS</p> <input type="checkbox"/> Apert Syndrome (FGFR2) <input type="checkbox"/> Antley Bixler-like Syndrome (FGFR2) <input type="checkbox"/> Crouzon Syndrome (FGFR2, 3) <input type="checkbox"/> Jackson-Weiss Syndrome (FGFR2, 3) <input type="checkbox"/> Pfeiffer Syndrome (FGFR1, 2, 3) <input type="checkbox"/> Coronal Synostosis (FGFR2, 3) <input type="checkbox"/> Saethre-Chotzen Syndrome (FGFR2, 3; TWIST) <input type="checkbox"/> Crouzon with Acanthosis Nigricans (FGFR3) <input type="checkbox"/> Craniofrontonasal Syndrome (EFNB1) <input type="checkbox"/> Oculodentodigital Dysplasia (GJA1) <input type="checkbox"/> Treacher Collins Syndrome (TCOF1) <p>SKELETAL DYSPLASIAS (FGFR3-Related)</p> <input type="checkbox"/> Achondroplasia / Hypochondroplasia <input type="checkbox"/> Achondroplasia / Thanatophoric Dysplasia <input type="checkbox"/> SADDAN <input type="checkbox"/> Campomelic Dysplasia (SOX9) <p>HEMOGLOBINOPATHIES</p> <input type="checkbox"/> β thalassemia – α -globin sequencing + 619bp deletion <input type="checkbox"/> Hb S (Sickle Cell) and Hb C (α -globin) <input type="checkbox"/> Specified α -globin variant: (_____) <p>SURFACTANT DEFICIENCIES</p> <input type="checkbox"/> SFTPB (Surfactant Protein B) <input type="checkbox"/> SFTPC (Surfactant Protein C) <input type="checkbox"/> ABCA3 (Surfactant Deficiency)	<p>ENDOCRINE DISORDERS</p> <input type="checkbox"/> Albright Hereditary Osteodystrophy (GNAS1) <input type="checkbox"/> Pseudohypoadosteronism, 1A (SCNN1A / SCNN1B / SCNN1G) <p>PTEN-Related Syndromes</p> <input type="checkbox"/> Bannayan-Riley-Ruvalcaba Syndrome <input type="checkbox"/> Cowden Syndrome <input type="checkbox"/> Macrocephaly/Autism Syndrome <input type="checkbox"/> Proteus / Proteus-Like Syndromes <p>OTHER CONDITIONS</p> <input type="checkbox"/> Aplastic Anemia (TERT / TR) <input type="checkbox"/> Arrhythmogenic Right Ventricular Dysplasia (PKP2) <input type="checkbox"/> Ataxia Telangiectasia (ATM) <input type="checkbox"/> Cystic Fibrosis: CFTR sequencing <input type="checkbox"/> Cystic Fibrosis Intron 8 T/TG tract <input type="checkbox"/> Non-Classical CF-Like phenotype (SCNN1B-related; CFTR negative) <input type="checkbox"/> Duchenne/Becker Muscular Dystrophy Linkage Analysis <input type="checkbox"/> Dyskeratosis congenita (autosomal dominant (TERT / TR))	<p>OTHER CONDITIONS</p> <input type="checkbox"/> Idiopathic Pulmonary Fibrosis (TERT / TR) <input type="checkbox"/> Liddle Syndrome (SCNN1B and SCNN1G) <input type="checkbox"/> Loeys-Dietz Aortic Aneurysm Syndrome (TGFB2 / TGFB1) <input type="checkbox"/> Marfan Syndrome (Type 2; TGFB2) <input type="checkbox"/> Transthyretin Amyloidosis (TTR) von Hippel-Lindau Syndrome (VHL) <input type="checkbox"/> Gene sequencing; reflex to MLPA <input type="checkbox"/> Complete sequence plus MLPA _____ <input type="checkbox"/> Maternal cell contamination study <p>Notes/Clinical Information:</p> <p>*Targeted mutation testing for any of the above conditions – Must be arranged with the lab prior to shipping. Call 410-955-0483.</p>			

Informed Consent:

I understand that my physician is requesting the DNA Diagnostic Lab of the Johns Hopkins School of Medicine to perform the genetic test selected above on me / my child. The purpose and accuracy of this testing have been reviewed by my health care provider and my questions about these issues have been answered. In some cases it is necessary to do an indirect test that does not identify a specific disease causing mutation. If I am to have an indirect test, my health care provider has discussed these issues with me. I understand that in most cases, a negative test result does not necessarily rule out a genetic condition. Results of genetic testing should be considered with the results of other types of testing and clinical evaluation. Lack of cooperation of all needed family members may compromise the quality or decrease the accuracy of the result obtained. If multiple family members are being tested, non-paternity may be disclosed by these results. No clinical tests other than those authorized will be performed, however, any remaining sample may be used quality control purposes or research after de-identification. The laboratory cannot guarantee turn around time or that a result will be obtained on any sample. Results will be released only to parties indicated on the test requisition or their agents. Release to other parties requires written consent of the patient.

Signed: _____

Date: _____

Alternate Consent:

I, the health care provider requesting the above testing, have explained the benefits and drawbacks of genetic testing to the patient and have obtained verbal consent or an alternate written consent (please attach) to order the above test.

Signed: _____

Date: _____