

**Referrer Information**

Physician:

UPIN/NPI:

Genetic Counselor:

Email:

Institution:

Address:

Phone:

Fax:

Additional reports to:

Address:

Phone:

Fax:

**Mandatory Signature**

I have confirmed that the patient has consented for the testing ordered and that two matching identifiers are present on each page of this requisition.

Signature:

Date:

**Patient Information (\*two of these identifiers MUST also appear on the sample tube)**

Legal Name\* (Last):

(First):

Preferred Name (Last):

(First):

Date of birth\* (mm/dd/yy):

Sex assigned at birth:

Gender:

Patient ID/MRN\*:

Patient Address:

**Billing Information (contact Billing Coordinator at 443-287-2486 prior to submitting)**

Billing contact:

Phone:

Fax:

Email:

Inpatient

Referring Center

MD Medicaid

Self-pay

Patient Insurance

Medicare

**Shipping Address: 1812 Ashland Ave, Sample Intake; Rm 245, Baltimore, MD 21205**

Phone: 410-955-0483 | Fax: 410-367-3266 | [ddl@jhmi.edu](mailto:ddl@jhmi.edu) | [www.hopkinsmedicine.org/dnadiagnostic](http://www.hopkinsmedicine.org/dnadiagnostic)



Clinical Information

Patient Name:

DOB (mm/dd/yy):

Indication:

ICD Codes:

Please attach detailed medical records.

Ancestry:

- Northern European
- Western European
- Eastern European
- Middle Eastern
- African American
- African
- Hispanic
- Central/South American
- Caribbean
- Asian
- Pacific Islander
- Native American
- Other

Check here if testing is pregnancy-related

Sample Information

Sample Type

Blood and saliva are not acceptable if the patient has:

- Received blood products <2 weeks before specimen collection. Exceptions are made for pRBC-only transfusions.
- Received an allogenic bone marrow or stem cell transplant. Cultured skin fibroblasts are the only accepted specimen type in this case.
- Active hematologic malignancy; cultured skin fibroblasts are the recommended sample type.

Contact the lab with specific questions or concerns.

Collection Date:

- |   |   |
|---|---|
| <input type="checkbox"/> Whole Blood                | <input type="checkbox"/> Cord blood               |
| <input type="checkbox"/> Extracted DNA              | <input type="checkbox"/> Cleaned chorionic villi  |
| <input type="checkbox"/> Saliva                     | <input type="checkbox"/> Cultured chorionic villi |
| <input type="checkbox"/> Cultured skin fibroblasts* | <input type="checkbox"/> Cultured amniocytes      |
| <input type="checkbox"/> Other: _____               |   |

Isolation or extraction of nucleic acids must be performed in a CLIA-certified laboratory or a laboratory meeting equivalent (or more stringent) requirements as determined by the College of American Pathologists (CAP) and/or the Centers for Medicare and Medicaid Services (CMS).

Patient Informed Consent

I grant permission for Johns Hopkins Genomics to perform the genetic test listed on this form for me/my child. The results of genetic testing may be dependent upon the clinical information provided to the laboratory by my physician. The laboratory cannot guarantee turn-around-time. Risks and limitations of this test may include, but are not limited to, disclosure of unexpected family information (non-paternity, consanguinity), uninformative negative results, unexpected findings, and lab error. De-identified clinical or genetic information may be used for quality control purposes, research, and shared in public healthcare databases. Results will be released only to the providers authorized on the test requisition. I understand the benefits, risks, and limitations of this genetic testing.

Signature:

Date:

Provider 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 test indicated. I have confirmed that the patient has consented for the testing ordered and that two matching identifiers are present on each page of this requisition.

Signature:

Date:

**Patient Information**

Patient Name:

DOB:

**Test Directory**

**Zoom Panels** (See website for full gene lists)

**CraniofacialZoom**

**FancZoom**

**HemZoom**

Subpanels available:

- Congenital dyserythropoietic anemia
- Erythrocytosis
- Erythropoietic porphyria
- Hemoglobinopathy
- Megaloblastic anemia
- RBC enzymopathy/Hemolytic anemia
- RBC membranopathy/Hemolytic anemia
- Sideroblastic anemia
- Other anemias

**Low Bone DensityZoom**

**MarrowZoom**

**NeuromuscularZoom**

Subpanels available:

- Myopathy
- Charcot-Marie-Tooth
- Hereditary spastic paraplegia

**PulmZoom**

Subpanels available:

- Mucociliary disorders
- Interstitial lung disease
- Pulmonary vascular disease

**RenalZoom**

Subpanels available:

- CAKUT, ciliopathies, and tubulointerstitial diseases
- Disorders of ion transport, nephrolithiasis, and nephrocalcinosis
- Glomerular disease and complement genes

**SkeletalZoom**

**Stickler22qZoom**

**TeloZoom** (does not include Telomere Length Testing)

**Targeted Variant(s)**

Gene \_\_\_\_\_ c. \_\_\_\_\_ p. \_\_\_\_\_

Gene \_\_\_\_\_ c. \_\_\_\_\_ p. \_\_\_\_\_

Relationship to proband: \_\_\_\_\_

*\*Please attach copy of previous report and phenotypic information*

**Prenatal Tests**

Maternal cell contamination study only

Targeted variant(s)

Gene \_\_\_\_\_ c. \_\_\_\_\_ p. \_\_\_\_\_

Gene \_\_\_\_\_ c. \_\_\_\_\_ p. \_\_\_\_\_

Relationship to proband: \_\_\_\_\_

*\*Please attach copy of previous report*

**Please ship samples to:**

1812 Ashland Ave

Sample Intake; Rm 245

Baltimore, MD 21205

*For sample specific requirements  
please visit our website.*