

**Referrer Information**

Physician:	UPIN/NPI:
Additional provider:	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):	
Name (if different than legal name) Last:	First:	
Date of birth* (mm/dd/yyyy):	Sex assigned at birth:	Gender:
Patient ID/MRN*:		
Patient Address:		

**Billing Information (contact Billing Coordinator at 667-306-8282 prior to submitting)**

Billing contact:					
Phone:	Fax:	Email:			
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Referring Center	<input type="checkbox"/> MD Medicaid	<input type="checkbox"/> Self-pay	<input type="checkbox"/> Patient Insurance	<input type="checkbox"/> Medicare

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

**Clinical Information**

Patient Name:

DOB (mm/dd/yyyy):

ICD Codes:

Indication (*Please attach detailed clinical notes*):

**Ancestry**

- Black, African American, or of African descent
- East Asian
- Middle Eastern, Southwest Asian, North African
- Hispanic, Latino/Latina/Latinx
- Native American, Alaska Native, First Nations
- Native Hawaiian, Pacific Islander
- South Asian
- Southeast Asian
- White
- Other: \_\_\_\_\_

**Sample Information**

**Sample Type**

Collection Date and Time:

- |  |   |
|--|---|
| <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"/> Buccal Swab (2)           | <input type="checkbox"/> Cultured amniocytes      |
| <input type="checkbox"/> Cultured skin fibroblasts |   |

Blood, saliva, and buccal samples 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.*

*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**

**HemeZoom** (select desired subpanels)

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

**IonChannelZoom**

**LowBoneDensityZoom**

**MarrowZoom**

**NeuromuscularZoom** (select desired subpanels)

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

**PulmZoom** (select desired subpanels)

- Mucociliary disorders
- Interstitial lung disease
- Pulmonary vascular disease

**RenalZoom** (select desired subpanels)

- 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)

**Cystic Fibrosis**

**CFTR whole gene sequencing**

**Targeted Variant Testing**

*\*Please attach relevant prior reports and phenotypic information*

**Familial Variant(s)**

Gene 1: \_\_\_\_\_ c. \_\_\_\_\_ p. \_\_\_\_\_

Gene 2: \_\_\_\_\_ c. \_\_\_\_\_ p. \_\_\_\_\_

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

Family genetic ID (if known): \_\_\_\_\_

**VUS Resolution**

Gene 1: \_\_\_\_\_ c. \_\_\_\_\_ p. \_\_\_\_\_

Gene 2: \_\_\_\_\_ c. \_\_\_\_\_ p. \_\_\_\_\_

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

Proband genetic ID: \_\_\_\_\_

*DDL approval required; see VUS Resolution Policy for details*

**Prenatal Testing**

*\*Please attach relevant prior reports and phenotypic information*

**Maternal cell contamination study only**

**Targeted variant(s)**

Gene 1: \_\_\_\_\_ c. \_\_\_\_\_ p. \_\_\_\_\_

Gene 2: \_\_\_\_\_ c. \_\_\_\_\_ p. \_\_\_\_\_

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

Family genetic ID (if known): \_\_\_\_\_

**Please ship samples to:**

1812 Ashland Ave

Sample Intake; Rm 245

Baltimore, MD 21205

*For sample specific requirements please visit our website.*