JOHNS HOPKINS MEDICINE

Johns Hopkins Genomics
DNA Diagnostic Laboratory

General Requisition Form - Page 1

v120320

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 been 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:

☐ Referring Center ☐ Maryland Medicaid ☐ Self-pay ☐ Patient Insurance ☐ Medicare

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

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General Requisition Form - Page 2

v120320

Clinical Information

Patient Name:

DOB (mm/dd/yy):

Indication:

ICD Codes:

Please attach detailed medical records.

Ancestry:

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

Test ordered:

☐ **Check here if testing is pregnancy-related**

Sample Information

Sample Type

☐ Whole Blood
☐ Extracted DNA
☐ Cultured amniocytes
☐ Saliva
☐ Cultured fibroblasts*
☐ Cleaned chorionic villi
☐ Cultured chorionic villi
☐ Cord blood
☐ Other:_____

**Fibroblasts are the preferred sample type for patients with hematologic malignancies*

The DNA Diagnostic Laboratory only accepts isolated or extracted nucleic acids for which the extraction or isolation is 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).

Collection Date:

Collection Site (JH Only):

Has the patient had a **transfusion**? ☐ Yes ☐ No

If yes, was it PRBC transfusion only? ☐ Yes ☐ No

Has the patient had a **bone marrow transplant**? ☐ Yes ☐ No

If yes to any of the above, please contact the laboratory prior to sending.

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**
  Phenotypes included: craniofacial disorders
- **FancZoom**
  Phenotypes included: Fanconi anemia
- **Low Bone DensityZoom**
  Phenotypes included: fragile bones, osteopenia
- **MarrowZoom**
  Phenotypes included: thrombocytopenia, MDS and acute leukemias, short telomere disorders, Diamond-Blackfan anemia/DBA-like hypoplastic anemias, Fanconi anemia, severe congenital neutropenia, sideroblastic anemia
- **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**
  Phenotypes included: short-ribpolydactyly, skeletalciliopathies
- **Stickler22qZoom**
  Phenotypes included: Stickler syndrome, 22q deletion syndrome (DiGeorge syndrome)
- **TeloZoom**
  Phenotypes included: telomere shortening disorders

Lung Disease

- Neonatal respiratory distress NGS panel

Movement Disorders

- Huntington disease (*HTT* repeat sizing)
- Huntington disease like 2 (*JPH3* repeat sizing)

Targeted Variant(s)

Gene_____ c._____ p._____

Gene_____ c._____ p._____

Relationship to proband: _____

**Please attach copy of previous report*

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*

Clinical Exome Sequencing

Please see our website for the requisition form specific to exome sequencing

Please ship samples to:

1812 Ashland Ave
Sample Intake Rm 245
Baltimore, MD 21205

For sample specific requirements please visit our website.