

Children's Hospital Los Angeles  
Alexander R. Judkins, MD  
Department of Pathology & Laboratory Medicine  
Pathologist-in-Chief and Laboratory Director  
Phone: 323.361.2423, 877.543.9522  
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CLIA Number: 05D2097680  
CAP Number: 9277593  
California State License CDF-00347990

**Ship To:**

Department of Pathology and Laboratory Medicine  
Children's Hospital Los Angeles  
4650 Sunset Blvd.  
Duque Bldg., 2nd Floor, Room 2-290  
Los Angeles, CA 90027

**CPM Whole Genome Sequencing (WGS) Analysis Test Requisition**

All information must be completed before sample can be processed.

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

DOB (MM/DD/YYYY): \_\_\_\_\_ Gender: ☐ M ☐ F ☐ Unknown

Ancestry: ☐ African American ☐ Central/South American ☐ Native American  
☐ Ashkenazi Jewish ☐ Eastern European ☐ Northern European  
☐ Asian ☐ Hispanic ☐ Pacific Islander  
☐ Caribbean ☐ Middle Eastern ☐ Western European  
☐ Caucasian ☐ Other (Please specify): \_\_\_\_\_

MRN: \_\_\_\_\_

**CLINICAL INFORMATION**

Clinical Diagnosis or Indication for test: \_\_\_\_\_

**\*\* Please include clinical notes, copy of previous genetic test results, and signed consent form.**

**SAMPLE INFORMATION**

Date of Collection (MM/DD/YYYY): \_\_\_\_\_

Time Collected: \_\_\_\_\_ ☐ AM ☐ PM Collected By: \_\_\_\_\_

Specimen ID: \_\_\_\_\_

**SAMPLE TYPE (Please select one):**

- ☐ **BLOOD in EDTA (Lavender Top Tube)**
- ☐ **ISOLATED DNA FROM CLIA LAB** (specify source) \_\_\_\_\_
- ☐ Concentration: \_\_\_\_\_ (ug/ml) Volume \_\_\_\_\_ (ul)

Patient has had a transfusion? ☐ Yes ☐ No If "Yes," please contact the lab.

SEE PAGE 2 FOR SAMPLE REQUIREMENTS AND  
SHIPPING INSTRUCTIONS.

**For Internal Use Only:**

Date Received: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time Received: \_\_\_\_:\_\_\_\_ AM/PM

**REPORTING INFORMATION**

Hospital/Laboratory Name: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Secure Fax: \_\_\_\_\_

☐ Send Duplicate Report to:

Physician: \_\_\_\_\_

NPI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Physician Signature (Required): \_\_\_\_\_

**BILLING INFORMATION**

**PLEASE NOTE: We only bill the submitting institution. We do not bill third parties.**

Referring Institution \_\_\_\_\_

CHLA Account Number:\* \_\_\_\_\_

Hospital/Laboratory Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Accounts Payable Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

\*See reverse side to open an account with CHLA Laboratory.

**TEST ORDER**

- ☐ **Whole Genome Seq Analysis— Trio (CPT CODES 81425, 81426 X 2)**
- ☐ **Whole Genome Seq Analysis— Proband (CPT CODE 81425)**
- ☐ **Whole Genome Seq Analysis— Quad (CPT CODES 81425, 81426 X 3)**
- ☐ **Whole Genome Seq Analysis— Duo (CPT CODES 81425, 81426)**
- ☐ **Whole Genome Seq Analysis— Family Member (CPT CODE 81426)**

10/12/2022

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**SHIPPING AND HANDLING INSTRUCTIONS****BLOOD:**

1. Collect blood in EDTA (lavender top tube). Child or Adult: 2-3 ml
2. Ship sample same day (overnight). **DO NOT FREEZE**. Blood must be received in laboratory within 2 days of collection.
3. Minimum volume for **newborns** is 0.5 ml. Please call the laboratory to discuss volumes for a newborn.

**DNA:**

1. Ship 3 ug DNA in 1.5 ml screw cap microtube.
2. Ship sample with sufficient ice to maintain a temperature of 4°C.
3. DNA should be extracted in a CLIA lab.

**GENERAL INSTRUCTIONS:**

1. We will notify you within 24 hours of receipt if we are unable to perform testing due to compromised sample integrity.
2. Please notify us ASAP in writing if you wish to cancel a test. Cancellations cannot be accepted once testing has been initiated.
3. We accept samples Monday through Thursday from 7:00 AM to 4:00 PM PST. We also accept samples on Friday by 11:00 AM PST. All packages should be mailed for receipt by Friday. Holidays and weekends should be taken into consideration before mailing samples.
4. To ensure sample integrity, use of the following delivery priorities is highly recommended. **Please provide tracking number at the time of shipment.**  
FedEx: First Overnight  
UPS: Next Day Air Early AM
5. **Your specimen is important to us. Please email the tracking number to [PLMTrack@chla.usc.edu](mailto:PLMTrack@chla.usc.edu) at the time of shipment and include contact information to be used in the event your sample is not received.**

**BILLING INFORMATION**

1. For billing inquiries, please call (877) 543-9522.
2. If you are interested in opening an account with Children's Hospital Los Angeles, please contact our Laboratory Service Center at (877)543-9522. Please be prepared to provide the following information:
  - a. Name of Institution
  - b. Address
  - c. Phone/Fax Number
  - d. Laboratory Contact Name and phone number
  - e. Accounts Payable Contact Name and phone number

**CONTACT US**

For all other inquiries, please contact our Laboratory Service Center at:  
**(877)KIDZ-LAB or (877) 543-9522**  
or via email at [askcpm@chla.usc.edu](mailto:askcpm@chla.usc.edu)  
Visit our website at:  
**[CHLA.org/CPM](http://CHLA.org/CPM)**