Children's Hospital Los Angeles
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Children's Hospital LOS ANGELES
DEPARTMENT OF PATHOLOGY & LABORATORY MEDICINE
877-KIDZLAB

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

CLINICAL EXOME SEQUENCING 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 ☐Ashkenazi Jewish ☐Asian ☐Caribbean ☐Caucasian ☐Central/South American ☐Eastern European ☐Hispanic ☐Middle Eastern ☐Other (Please specify):________________ ☐Native American ☐Northern European ☐Pacific Islander ☐Western European

MRN: ______________________________

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)**
☐ **DNA EXTRACTED FROM BLOOD**

Concentration: ______________(ug/mL) Volume ________(uL)

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

CLINICAL EXOME SEQUENCING TEST MENU (PLEASE SELECT ONE)

☐ **CLINICAL EXOME SEQUENCING - PROBAND ONLY (CPT Code 81415)**

☐ **CLINICAL EXOME SEQUENCING - TRIO (CPT Code 81415, 81416x2)**
(Child and both parents preferred; Trio testing will begin when all samples have been received in lab.)

1) Proband/Child Full Name: ______________________________

DOB (MM/DD/YYYY): ______________________________

2) Biological Parent Sample Information:
MOTHER: ☐ Not Available ☐ To be sent later
☐ Asymptomatic ☐ Symptomatic (attach summary of findings)

____
Last Name First Name DOB

FATHER: ☐ Not Available ☐ To be sent later
☐ Asymptomatic ☐ Symptomatic (attach summary of findings)

____
Last Name First Name DOB

☐ **CLINICAL EXOME SEQUENCING - OTHER FAMILY MEMBER (CPT Code 81416)**
OTHER: ☐ Not Available ☐ To be sent later
☐ Asymptomatic ☐ Symptomatic (attach summary of findings)

Proband/Child Full Name: ______________ ______________

DOB (MM/DD/YYYY): ____________Relationship to Proband:____________

☐ **TARGETED MUTATION ANALYSIS - OTHER FAMILY MEMBER (CPT Code 81403, 81479, G0452)**
Gene(s): ______________Mutation(s)______________

Proband/Child Full Name:______________________________

DOB (MM/DD/YYYY): ____________Relationship to Proband:____________

Note: If a previous test was performed at another lab, please include (1) a positive control and (2) a copy of test report of the positive family member. Consent form is not required

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: ________

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.

CHECKLIST OF INFORMATION REQUIRED TO PERFORM TESTING

☐ TEST REQUISITION FORM COMPLETED FOR EACH SAMPLE

☐ SIGNED CONSENT FORM FOR EACH INDIVIDUAL TO BE TESTED

☐ CLINICAL HISTORY FORM

☐ RELEVANT MEDICAL RECORDS, INCLUDING PREVIOUS GENETIC TEST RESULTS

☐ COPY OF PRE-AUTHORIZATION (If applicable)

Note: Orders with missing requirements will be placed on hold until all requirements are received. Turnaround time is 12 weeks once all requirements are received and financial responsibility has been verified.

CLINICAL INFORMATION

Clinical Diagnosis or Indication for test: ______________________________

For Internal Use Only:

Date Received: _____/_____/_____ Time Received: _____: _____ AM /PM

Technician: ______________________________

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SAMPLE REQUIREMENTS

BLOOD IN EDTA (lavender top tube):

Minimum Volume: Newborn or Infant: Please contact the lab Child or Adult: 2-3 mL

DNA EXTRACTED FROM BLOOD (1.5 mL screw cap tube)

2-4ug (minimal concentration of 50 ng/ul and A260/A280 of ~1.8)
(extracted in accordance with CAP/CLIA guidelines)

SHIPPING AND HANDLING INSTRUCTIONS

BLOOD:

1. Collect blood in EDTA (lavender top tube).
2. Ship blood same day (overnight) at 4°C. DO NOT FREEZE. Blood must be received in laboratory within 2 days of collection.

DNA:

1. Ship DNA sample in a 1.5 mL screw cap tube.
2. Ship DNA sample at 4°C.

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 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
3. Third party billing is not offered at this time.

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**

Visit our website at:

CHLA.org/CPM