Children's Hospital Los Angeles
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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

BRAF (EXON 15) SANGER 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

MRN: ____

CLINICAL INFORMATION

Clinical diagnosis or Indication for test: ______________________________

SAMPLE INFORMATION

Date of Collection (MM/DD/YYYY):______________________________________

Time Collected: __________ ☐AM ☐PM Collected By: ____________________

Tumor Site: __________________________________ ☐Primary ☐Metastasis

If metastasis, please list primary site: ______________________________

SAMPLE TYPE (Please select one):

☐ **FRESH FROZEN TISSUE**

☐ In cryotube or foil ☐ In OCT block

☐ **PARAFFIN EMBEDDED TISSUE**

☐ FFPE Block(s) ☐ Scrolls (H&E slide required)

Block ID Number(s): ____

☐ **DNA EXTRACTED FROM**______________________________________

Block ID Number: ____

Estimated percent of tumor in sample:_____________________________

Concentration: ___________________(ug/mL) Volume ____________(uL)

(extracted in accordance with CAP/CLIA guidelines)

BRAF TEST ORDER

☐ **BRAF (EXON 15) SANGER SEQUENCING (CPT Code 81210)**

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
☐ PATHOLOGY REPORT

SEE PAGE 2 FOR SAMPLE REQUIREMENTS AND SHIPPING INSTRUCTIONS.

For Internal Use Only:

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

Technician: ____

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

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SAMPLE REQUIREMENTS

FRESH FROZEN TISSUE (cryopreservation tube or sterile foil or OCT block)

0.25 cm^3 tissue (~100mg) should be snap frozen immediately after surgery and stored at -80°C

PARAFFIN EMBEDDED TISSUE (block or scrolls in 1.5 mL tube)

5 scrolls cut at 20 um

DNA EXTRACTED FROM FRESH FROZEN TISSUE OR PARAFFIN EMBEDDED TISSUE (1.5 mL screw cap tube)

2 ug (minimal concentration of 50ng/ul and A260/A280 of ~1.8)

SHIPPING AND HANDLING INSTRUCTIONS

FRESH FROZEN TISSUE:

1. Ship fresh frozen tissue on dry ice with a minimum of 5 kg of dry ice. Overnight delivery required to prevent thawing of tissue.

PARAFFIN EMBEDDED TISSUE :

1. Ship FFPE block or scrolls in 1.5 mL tube at ambient temperature. Include corresponding H&E slide.

DNA:

1. Ship DNA in 1.5 mL screw cap tube 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