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 Fax: 323.361.6157 CLIA Number: 05D2097680 California State License CLF260 CAP Number: 9277593



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 REQUISITION

All information must be completed before sample can be processed.

PΔ	TIENT INFORMATION	REPORTING INFORMATION	
		Hospital/Laboratory Name:	
Last Name	First Name MI	Contact Name:	
DOB (MM/DD/YYYY):	Gender: 🗆 M 🗆 F 🗆 Unknown	Address:	
Ancestry:  African American Ashkenazi Jewish Asian Caribbean	□Eastern European □Northern European □Hispanic □Pacific Islander □Middle Eastern □Western European	City:          Zip Code:           Phone:          Fax:	
	Other (Please specify):	_	
MRN:		Send Duplicate Report to:	
SAMPLE INFORMATION		Physician:	
Date of Collection (MM/DD/YYYY):		NPI:	
Time Collected: [	AM DPM Collected By:	Address:	
Specimen ID:		City: State: Zip Code:	
SAMPLE TYPE (Please select one):		BILLING INFORMATION	
BLOOD IN EDTA (lavender top tube) DNA EXTRACTED FROM BLOOD		Referring Institution	
Concentration: (ug/mL) Volume (uL)		CHLA Account Number :	
Patient has had a transfusion?  Yes  No If "Yes," please contact the lab.		Hospital/Laboratory Name:	
		Address:	
CLINICAL EXOIVIE SEC	QUENCING TEST MENU (PLEASE SELECT ONE)	City: Zip Code:	
CLINICAL EXOME SEQUENCING - PROBAND ONLY		Accounts Payable Contact Name:	
LICLINICIAL EXOME SEQUENCING - TRIO (Child and both parents preferred; Trio testing will begin when all samples have been		Phone: Fax:	
received in lab.) 1) Proband/Child Full Name:		Email:	
DOB (мм/dd/үүүү):		*See reverse side to open an account with CHLA Laboratory.	
2) Biological Parent Sample Information:		CHECKLIST OF INFORMATION REQUIRED TO PERFORM TESTIN	
MOTHER: Not Available	☐ To be sent later ☐ Symptomatic (attach summary of findings)	TEST REQUISITION FORM COMPLETED FOR EACH SAMPLE	
Last Name	First Name DOB	SIGNED CONSENT FORM FOR EACH INDIVIDUAL TO BE TESTED	
FATHER: 🗌 Not Available	To be sent later		
Asymptomatic	Symptomatic (attach summary of findings)	□ RELEVANT MEDICAL RECORDS, INCLUDING PREVIOUS GENETIC TEST RESULTS	
Last Name	First Name DOB	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	
OTHER: ONt Available	ING - OTHER FAMILY MEMBER  To be sent later  Symptomatic (attach summary of findings)	financial responsibility has been verified.	
Proband/Child Full Name:		SEE PAGE 2 FOR SAMPLE REQUIREMENTS AND	
DOB (MM/DD/YYYY):Relationship to Proband:		SHIPPING INSTRUCTIONS.	
TARGETED MUTATION ANA	ALYSIS - OTHER FAMILY MEMBER		
Gene(s):Mutation(s)		For Internal Use Only:	
Proband/Child Full Name:		Date Received:// Time Received::AM /PM	
DOB (MM/DD/YYYY):Relationship to Proband:			
Note: If a previous test was per control and (2) a copy of test re required	formed at another lab, please include (1) a positive port of the positive family member. Consent form is not	Technician:	

DCN: 3-100.1

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Child or Adult: 3-5 mL

SAMPLE REQUIREMENTS

### **BLOOD IN EDTA (lavender top tube):**

Minimum Volume: Newborn or Infant: Please contact the lab

## DNA EXTRACTED FROM BLOOD (1.5 mL screw cap tube)

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

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  $4^{\circ}$ C.

### **GENERAL INSTRUCTIONS:**

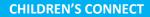
- 1. We will notify you within 24 hours of receipt if we are unable to perform testing due to compromised sample integrity.
- 2. Please notify us ASAP in writing if you wish to cancel a test. Cancellations cannot be accepted once testing has been initiated.
- 3. We accept samples Monday through Thursday 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:

FedEx: First Overnight UPS: Next Day Air Early AM

5. Your specimen is important to us. Please email the tracking number to <u>PLMTrack@chla.usc.edu</u> at the time of shipment and <u>include</u> <u>contact information</u> 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.



Children's Connect is a web-based portal providing 24/7 access to laboratory test order entry and results retrieval.

To request access or to receive more information, please contact us at:

(877) 543-9522.



# CONTACT US

For all other inquiries, please contact our Laboratory Service Center at:

(877)KIDZ-LAB or (877) 543-9522

or visit our website at: CHLA.org/CPM