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

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 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**

☐ **CLINICIAL EXOME SEQUENCING - TRIO**
(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**

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**

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

DCN: 3-100.1

REPORTING INFORMATION

Hospital/Laboratory Name: _____

Contact Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: _____ Fax: _____

☐ Send Duplicate Report to:

Physician: _____

NPI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

BILLING INFORMATION

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.

SEE PAGE 2 FOR SAMPLE REQUIREMENTS AND SHIPPING INSTRUCTIONS.

For Internal Use Only:

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

Technician: _____

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

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

SAMPLE REQUIREMENTS

BLOOD IN EDTA (lavender top tube):

Minimum Volume: Newborn or Infant: Please contact the lab Child or Adult: 3-5 mL

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°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 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.

CHILDREN'S CONNECT

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.

Children's Hospital LOS ANGELES
Children's Connect
LABORATORY

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