Children's Hospital Los Angeles
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Phone: 323.361.2423, 877.543.9522
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Children's Hospital LOS ANGELES
CENTER FOR PERSONALIZED 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

CPM Vascular Anomalies and Mosaic Disorders (VMD4Kids) Test Requisition

All information must be completed before sample can be processed.

PATIENT INFORMATION

_____, _____ _____
Last Name First Name MI

DOB (MM/DD/YYY): _____ 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 and copy of any genetic test results**

SAMPLE INFORMATION

Date of Collection (MM/DD/YYY):_____

Time Collected: _____ ☐AM ☐PM Collected By: _____

Specimen ID: _____

SAMPLE TYPE (Please select):

☐ **BLOOD IN EDTA** (lavender top tube)

☐ **ISOLATED DNA FROM CLIA LAB** (specify source)_____

□ Concentration: _____(ug/ml) Volume _____(ul)

☐ **SKIN BIOPSY** (In CHANG medium)

☐ **FRESH FROZEN TISSUE** ☐ In cryotube or foil ☐ In OCT block

Source: _____

☐ **PARAFFIN EMBEDDED TISSUE**

□ **FFPE block(s)**

□ **Scrolls (H&E slide required)**

Block ID Number(s): _____

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

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

☐ **CPM VMD4Kids (CPT CODE 81479)**

SEE PAGE 2 FOR SAMPLE REQUIREMENTS AND SHIPPING INSTRUCTIONS.

For Internal Use Only:

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

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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.

SKIN BIOPSY:

1. Skin biopsy 2-5 mm submitted in either CHANG medium or other transport media substitute.
2. Store at room temperature. If stored longer than 24 hours, please store at 4°C.

PARAFFIN EMBEDDED AND FRESH FROZEN TUMOR TISSUE:

1. Tissue should be snap frozen immediately after surgery and placed in cryopreservation vials, sterile foil, or a cassette.
2. If frozen tissue is not available, send a tissue block.
3. If a FFPE block is not available, send 10 scrolls cut at 20 microns in two 1.5 ml tubes and a H&E slide, cut and stained from the adjacent section.
4. Label samples with patient's first and last name, Date of Birth (DOB), and the surgical number of the tissue.
5. Immediately before shipping, pack frozen vials of tissue in dry ice.
6. Place this requisition and pathology report(s) in a plastic Ziploc bag. Place the Ziploc bag or envelope on top of the Styrofoam lid but inside of the cardboard box. Secure the cardboard box with tape.

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

10/12/2022