

Patient Identification/ Label				ODTC #:		MP #:			
				Wsh #:					
				DOB:					
				Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female					
				Specimen Collection					
				Date		Time	By		
Ordering Physician/ Ordering PI		(LAST)	(FIRST)	(Initial)	Physician's ID #		Contact #:	Loc/Clinic/ILab:	

### Specimen Information

Please select one and specify the amount.

- Blood (2cc in Lav top required for each test) \_\_\_\_\_
- DNA (1 µg minimum) \_\_\_\_\_
- Blood spot \_\_\_\_\_
- Buccal brush \_\_\_\_\_
- Amniotic fluid \_\_\_\_\_
- Tissue: (≥0.2g) Source: \_\_\_\_\_
- Paraffin block/ section: \_\_\_\_\_
- Culture, type: \_\_\_\_\_

Call Lab for Special Instructions: (310) 794-2781

### Information Requested by ODTC:

Please mark:

- A diagram or sequence of the gene with primer and mutation sites indicated.
- The sequencing autoradiogram or chromatogram of the amplicon, if required.
- A photo of the agarose gel containing the amplicon and the size markers.
- Positive and negative DNA controls.
- Forward and reverse primers for amplification, if required.
- References.

**Technical Information:**

1- Indication for the test \_\_\_\_\_

2- The name of gene to be tested and GDB accession #: \_\_\_\_\_

3- Detailed description of the mutation: \_\_\_\_\_

\_\_\_\_\_

4- The PCR and cycling conditions, in detail: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5- PCR buffer: \_\_\_\_\_

6- The anticipated size of the amplicon: \_\_\_\_\_

7- Forward and reverse primers:

Names: \_\_\_\_\_

Forward sequence: \_\_\_\_\_

Reverse sequence: \_\_\_\_\_

Concentrations: \_\_\_\_\_

8- Contact names and numbers \_\_\_\_\_

\_\_\_\_\_



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Phone: (310) 206-3694



**INSTRUCTIONS FOR REFERRED TESTING**

**SPECIMEN:** Follow specimen instructions on the front of this form.  
Label all specimens with Patient name, I.D. numbers, date and time of collection.

**INFORMATION:** Fill out Client Information, Patient Information, Specimen Information and Technical Information areas of this form. Include all the information requested by ODTC.  
Submit a separate form for each patient (copies are acceptable).

**Mail:** Send all specimens except DNA, and forms Monday through Thursday to:

UCLA Medical Center, Clinical Laboratories  
Rm A7-147 CHS  
10833 Le Conte Ave  
Los Angeles, CA 90095-1713

**PLEASE SHIP  
OVERNIGHT EXPRESS**

Attn: **Support Services Supervisor**

Send all the DNA samples and forms Monday through Thursday to:

UCLA, Gonda Building,  
Orphan Disease Testing Center  
Rm 5309  
695 Charles E. Young Dr. South  
Los Angeles, CA 90095-7088

**PLEASE SHIP  
OVERNIGHT EXPRESS**

**For further information:** Please call (310) 206-3694, UCLA Orphan Disease Testing Center

**REFERRING LABORATORY/PHYSICIAN INFORMATION**

<b>Name</b>			<b>Phone FAX</b>
<b>Address</b>	<b>City</b>	<b>State</b>	<b>ZIP</b>
<b>Requesting physician/ PI</b>		<b>UPIN</b>	<b>Phone</b>

**BILLING INFORMATION**

**BILL TO:**  Physician/Referring Laboratory (Client)  
 Patient: Payment must accompany test request  
 Payment should be made out to: University of California Regents

For additional billing information please call the Department of Pathology Business office at (310) 825-8591