

Patient Name:				Requisition #			
Date of Birth:				Specimen Description SS L R GN BK GY GLD			
Pt. Gender: M or F				Loc/Clinic:		Specimen Collection	
Pt MR#				Date		Time	By
Ordering Physician (LAST) (FIRST) (Initial)			Physician's ID #	Beeper / Extension:		Specimen Comment:	
Other Physician (LAST) (FIRST) (Initial)			Physician's ID #	Pt. Ethnicity:		DOB: _____ Sex: <input type="radio"/> Male <input type="radio"/> Female	
COPY TO:							

PLEASE PRINT LEGIBLY

SPECIMEN TYPE	
<input type="checkbox"/>	Blood (see box)
<input type="checkbox"/>	Amniotic Fluid (2 ml minimum)
<input type="checkbox"/>	Bone Marrow (2-3 ml)
<input type="checkbox"/>	Buccal Brush (Call Lab for Special Instructions: 310-794-2781)
<input type="checkbox"/>	Tissue: (≥0.2g) Source: _____
<input type="checkbox"/>	Paraffin block: _____
<input type="checkbox"/>	Case # as applicable: _____
<input type="checkbox"/>	Referring Pathology: _____

PATIENT INFORMATION/HISTORY	
Pertinent Family History:	
Primary Counseling Issue for Genetic Disease	
<input type="checkbox"/>	Proband Diagnosis
<input type="checkbox"/>	Prenatal Diagnosis
<input type="checkbox"/>	Carrier Screen
<input type="checkbox"/>	Presymptomatic Diagnosis
<input type="checkbox"/>	OTHER:

Notice to Ordering Physicians	
Patient Diagnosis:	
Medical Necessity for test(s) requested MUST be indicated by ICD-9 Codes:	
Notes/Special Instructions:	

Molecular Genetic Testing	
9224	BRCA 1 / 2 Ashkenazi Jewish Mutations
2962	Cystic Fibrosis Mutation Panel
9009	Factor V-Leiden Mutation
9223	Familial Mediterranean Fever Mutations
2876	Fragile X Mutations
9032	Freidreich's Ataxia Mutation
9262	Hereditary Hemochromatosis (HFE)
9033	Huntington's Disease Mutation
9234	Prothrombin Gene Mutation (20210A Variant)
16516	MTHFR Variants Detection NBS 657del5 mutation

Bone Marrow Engraftment	
Please select one:	
3260	Recipient PRE -Transplant (RFLP)
3312	Recipient POST -Transplant (RFLP)
3261	Recipient POST-Txp Follow-up (RFLP)
3313	DONOR
<input type="checkbox"/>	Male
<input type="checkbox"/>	Female
<input type="checkbox"/>	Related
<input type="checkbox"/>	Unrelated
Donor's Full Name	
Recipient's Full Name	

DNA Repair Disorders (Ataxia-telangiectasia, Nijmegen Breakage Syndrome, Fanconi Anemia, and Others)	
<i>Min Req: 3 – 7ml GREEN top (sodium heparin)</i> Phone: (310) 825-7200	
Please select one:	
9040	Radiosensitivity/Immunoblot combo DO NOT REFRIGERATE
9041	Prenatal Diagnosis DO NOT REFRIGERATE

Molecular Oncology Testing	
9242	B Cell Gene Rearrangement *
9244	T Cell Gene Rearrangement *
*Reflex test for southern blot if PCR result is negative	
3278	Bcl-2 Gene Rearrangement
3276	BCR-ABL Gene Rearrangement
9993	Microsatellite Instability (MSI) (Colon Cancer)
16745	JAK2 Mutation Detection
16706	PML/RARα t(15;17) Translocation
16793	FLT3 Mutations: ITD & D835
16808	c-KIT Mastocytosis Mutations KRAS Gene Mutations (Colon cancer)

Miscellaneous Molecular Testing	
3262	DNA Isolation
3314	DNA Fingerprinting; Specimen Identification (2 specimens)
9360	DNA Fingerprinting; Specimen Identification (3 specimens)
9227	Sex Determination/ Y-Chromosome Probe

Please complete if ordering test below:	
Paternity Testing	
9952	Child's Full Name:
9304	No Mother available
9038	Mother's Full Name:
9039	Alleged Father #1 Name:
9019	Alleged Father #2 Name:
9018	Sibling's Name:

Misc. Test Add-ins	

Twin Zygosity	
9036	Twin #1 Name:
	Twin #2 Name:
	Mother Name:
	Father Name:
9989	No parents available

UCLA Medical Center, Department of Pathology and Laboratory Medicine
Elizabeth A. Wagar, M.D. Director of Laboratories
Box 951713, Los Angeles CA 90095-1713



Diagnostic Molecular Pathology
Wayne W. Grody, M.D. Ph.D, Medical Director
Richard A. Gatti, M.D., Medical Co-Director
Phone: (310) 825-8080

Instructions for Referred Testing

Specimen: Follow specimen instructions on the requisition form.

Label all specimens with Patient name, I.D. numbers, date and time of collection.

*****To arrange for the "FC-SMC1" assay, please call (310) 825-7200 before drawing blood samples*****

Information: Fill out Client information, Patient information, and Specimen information areas.

Submit a separate form for each patient (copies are acceptable). Select test being requested.

Mail:

Please ship **OVERNIGHT EXPRESS AT ROOM TEMPERATURE.**

Send specimens with completed forms (**Monday through Thursday**) to:

**Pathology Outreach Services
Room 1P-201 CHS (Mail Code 173216)
10833 Le Conte Avenue
Los Angeles, CA 90095-1732**

For technical questions, please call (310) 825-7200, UCLA Molecular Pathology Laboratory

For billing questions, please call (800) 718 9505, GGB billing

Referring Laboratory / Physician Information

Name: _____ Phone: _____ FAX: _____

Address: _____
City State Zip

Requesting Physician: _____

UPIN: _____ Phone: _____ FAX: _____

Billing Information

We will bill Referring Institution, Laboratory or Physician.

If patient will be paying the bill, payment must accompany test request and should be made out to:
Regents of University of California.

For additional billing information please call the Department of Pathology billing service **GGB** at:
(800) 718-9505.

UCLA Healthcare

Department of Pathology and Laboratory Medicine