

FOR LAB USE ONLY
ACCESSION NO: _____
DATE & TIME RECEIVED: _____
TECHNICIAN: _____

**UAB MEDICAL GENOMICS LABORATORY**  
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[www.genetics.uab.edu/medgenomics](http://www.genetics.uab.edu/medgenomics)

**GENERAL LABORATORY TEST REQUEST FORM**

**THIS FORM MUST BE FILLED OUT COMPLETELY**

PATIENT NAME:		BIRTH DATE:	DAYTIME PHONE:	SEX:	SOC. SEC. NUMBER:
PATIENT'S ADDRESS:		CITY:	STATE:	ZIP CODE:	MED REC NUMBER:
EMAIL ADDRESS:			PARENT OR GUARDIANS NAME (IF MINOR):		
<input type="checkbox"/> Hemochromatosis <input type="checkbox"/> Factor V Leiden <input type="checkbox"/> Prothrombin <input type="checkbox"/> Fragile X <input type="checkbox"/> MCADD <input type="checkbox"/> Targeted analysis p.K329E (Tier 1) followed by Complete sequence analysis (Tier 2) as needed (Test 1 comprehensive) <input type="checkbox"/> Targeted analysis of p.K329E <i>only</i> (Test 1 Tier 1) <input type="checkbox"/> Targeted Mutation Analysis (Test 2) Proband _____			<input type="checkbox"/> von-Hippel Lindau (VHL) <input type="checkbox"/> Direct Sequencing (Tier 1) followed by Copy Number Analysis (Tier 2) as needed (Test 1 comprehensive) <input type="checkbox"/> Direct Sequencing only (Test 1 Tier 1) <input type="checkbox"/> Copy number analysis by MLPA <i>only</i> (Test 1 Tier 2) <input type="checkbox"/> Targeted Mutation Analysis (Test 2) Proband _____ <input type="checkbox"/> Prenatal Targeted Analysis (Test 3) Proband _____		
Facility where specimen obtained:			Physician's Name:		
Date:			Physician's Address:		
<b>REQUIRED</b> Diagnosis (ICD-9) Code (only in US):			Phone: _____ Fax: _____ NPI Number: _____ Email: _____		
ADDITIONAL REPORTS TO: Name: _____			Mailing Address: _____ _____ _____		
Is Patient Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date of LMP: _____			Please check if applicable: <input type="checkbox"/> Infectious diseases (AIDS, Hepatitis, etc)		
Specimen type: <input type="checkbox"/> Cheek Swabs; # Swabs: _____ <input type="checkbox"/> Peripheral Blood (EDTA); # Tubes: _____			<input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Direct CVS <input type="checkbox"/> Cultured CVS <input type="checkbox"/> Cultured Amniocytes <input type="checkbox"/> Other: _____		

**BILLING INFORMATION**

BILL INSTITUTION: (Please, provide name, address, and telephone number of entity responsible for payment)

Purchase Order Number: _____	Contact Name: _____
Billing address: _____	Phone #: _____
	Fax #: _____
	Email: _____

PAYMENT ENCLOSED:

- Cashier's Check  
 VISA®  MasterCard®  Discover®  American Express®

Card Number: _____	Expiration Date: _____
Name as it appears on card: _____	3-digit Security Code: _____
Cardholder Signature: _____	
Cardholder Email Address: _____	

BILL CONTRACTED INSURANCE COMPANY:

Please include a copy of patient's insurance card. For a list of our contracted insurance companies, please visit our website at [www.genetics.uab.edu/medgenomics](http://www.genetics.uab.edu/medgenomics), under "Billing". Please include a copy of pre-approval statement if payment has been authorized. **We also need the patient's credit card information so that any balance left after insurance pays may be applied to it.**

FILE INSURANCE CLAIM WITH NON CONTRACTED COMPANY

Patient must pay full payment for test up front, (credit card or cashier's check) but UAB will file a claim for reimbursement with the patient's insurance company. Please send a copy of patient's insurance card, front and back.

## **Informed Consent for DNA Testing**

I, \_\_\_\_\_, hereby agree to participate in testing using a DNA-based test. I understand that samples of blood will be drawn from me and/or members of my family by drawing blood, a procedure which carries very little risk. In addition, if prenatal diagnosis is involved, fetal cells obtained by amniocentesis or chorion villus sampling will be used. I understand that the blood and fetal samples will be used for the purpose of attempting to determine if I and members of my family are carriers of the disease gene, or are affected with, or at increased risk to someday be affected with this genetic disease. In addition, I hereby give permission to collect blood samples from my minor children, named below, to be used for DNA testing for the disease listed above.

Child's name	Date of Birth	Gender (F/M)

I understand that:

1. In some cases the DNA test directly detects an abnormality, called a mutation, in the gene, and the test is >99% accurate. Rare variations in the DNA of individuals can also cause uncertainty in predicting carrier status of diagnosis. Thus, the test is not 100% accurate, and the results will be reported as a probability.
2. An error in the diagnosis may occur if the true biological relationships of the family members involved in this study are not as I have stated. For example, non-paternity means that the father of an individual is not the person stated to be the father. This test may detect non-paternity, and it may be necessary to report this finding to the individual who requested testing.
3. Any erroneous diagnosis in a family member can lead to an incorrect diagnosis for other related individuals in question. I understand that the DNA analysis performed at the UAB Medical Genomics Lab for this disease is specific only with respect to it and in no way guarantees my health or the health of my unborn child. The accuracy of DNA analysis is entirely dependent on the clinical diagnosis made elsewhere, and the UAB Medical Genomics Lab cannot be responsible for erroneous clinical diagnosis made at other centers.
4. Generally, these tests are relatively new and are being improved and expanded continuously. The tests are not considered research, but are considered to be the best and newest laboratory service which can be offered. This testing is often complex and utilizes specialized materials so that there is always some small possibility that the test will not work properly or that an error will occur. There is a low error rate (perhaps 1 in 1000 samples) even in the laboratories. My signature below acknowledges my voluntary participation in this test, but in no way releases the laboratory and staff from their professional and ethical responsibility to me.
5. I understand that my sample is not being banked. The laboratory does not return DNA samples to individuals or physicians. However, in some cases it may be possible for the laboratory to reanalyze my remaining DNA upon request. The request for additional studies must be ordered by my referring physician/counselor and there will be an additional fee.
6. Because of the complexity of DNA based testing and the important implications of the test results, results will be reported to me only through a physician or genetic counselor whom I designate. The result reports are confidential; they will only be released to other medical professionals or other parties with my written consent. All laboratory data is confidential and will not be released within legal limit. Participation in DNA testing is completely voluntary.
7. I will receive a copy of this consent form.

Signature: \_\_\_\_\_  
Witnessed by: \_\_\_\_\_  
Date: \_\_\_\_\_

Physician's/Counselor's statement: I have explained DNA testing to this individual. I have addressed the limitations outlined above and have answered person's questions.

Signature: \_\_\_\_\_