# CLINICAL LABORATORY

**Molecular Diagnostics**

**(415) 514-8488 Fax (415) 514-8193**

**SHIP TO:** **UCSF Clinical Laboratories**
**Attn: Molecular Diagnostics Lab**
**185 Berry Street, Suite 100**
**San Francisco, CA 94107**

**PLEASE SHIP MONDAY-THURSDAY ONLY**

| Last Name | | First | M.I. |
|---|---|---|---|
| Date of Birth | Gender ☐ Male ☐ Female ☐ Unknown | Ethnicity/Family History | |
| Patient or Sample ID# | | Institutional Account # | |

## SPECIMEN INFORMATION

| Collection Date | Type of Specimen | | |
|---|---|---|---|
| | ☐ Serum | ☐ Urine | ☐ Product of Conception |
| | ☐ Plasma | ☐ CSF | Tissue Origin: |
| Collection Time | ☐ Whole Blood | ☐ CVS | ☐ Other (specify): |
| | ☐ Bone Marrow | ☐ Amniotic Fluid | |
| | | Weeks Gestation: | |

## CLIENT / BILLING INFORMATION

(Institutional Billing only. We DO NOT bill patients directly.)

| Institution Name | Ordering Physician/Contact Person | Telephone | Fax # for Reports |
|---|---|---|---|
| Department or Division | Genetic Counselor | Telephone | Fax |
| Address | Billing Contact | Telephone | Fax |
| City, State, Zip | Billing Address (if different) | City, State, Zip | |

For Genetic Testing Only. As the ordering physician/provider, I certify that the patient has been appropriately informed of the test benefits and limitations. Adequate genetic counseling has been offered and written informed consent was obtained.

Physician/Provider Signature: Date:

Indication For Testing / Comments / Special Request:

ICD10 Codes:

# OUTREACH SERVICES REQUISITION

## INHERITED DISORDERS

| Code | Test | Specimen |
|---|---|---|
| MCC | ☐ **Maternal Cell Contamination (maternal and fetal samples)** | LAV |

**In addition to EDTA whole blood, most genetic tests listed here can also be performed on amniotic fluid, CVS samples or cultured cells. For prenatal samples, we recommend submitting an EDTA whole blood sample from the mother and ordering Maternal Cell Contamination (MCC).**

| Code | Test | Specimen |
|---|---|---|
| ALSC9 | ☐ **C9orf72 Repeat Expansion** | LAV |
| MCFM | ☐ **Cystic Fibrosis, PCR for Common Mutations** | LAV |
| POLT | ☐ **Cystic Fibrosis CBAVD Poly T Mutation** | LAV |
| FRX | ☐ **Fragile X** | LAV |
| HHEM | ☐ **Hemochromatosis, Hereditary** | LAV |
| INVN | ☐ **Hemophilia A Inversion** | LAV |
| HUNT | ☐ **Huntington's Disease Triplet Repeat** | LAV |
| PWA | ☐ **Prader-Willi/Angelman Syndromes** | LAV |
| SMAPCR | ☐ **Spinal Muscular Atrophy** | LAV |

### THALASSEMIA & HEMOGLOBINOPATHY TESTING

| | | | | |
|---|---|---|---|---|
| HbA _ % | MCV _ fL | Date of last transfusion: |
| HbF _ % | RBC _ x10(9)/L | _ |
| HbA2 _ % | Fe _ µg/dL | Ethnicity: |
| Other Hb _ % | Ferritin _ µg/dL | _ |

| Code | Test | Specimen |
|---|---|---|
| ATHL | ☐ **Alpha Thalassemia Common Deletions** | LAV |
| HBCS | ☐ **Alpha Thalassemia Point Mutations (Hb CS, Hb Pakse, Hb Quon** | LAV |
| AGSQ | ☐ **Alpha-Globin Gene Sequencing** | LAV |
| BTHL | ☐ **Beta Thalassemia Mutations (incl. HbS, HbC, HbE)** | LAV |
| BDEL | ☐ **Beta Globin Gene Deletions** | LAV |
| BGSQ | ☐ **Beta-Globin Gene Sequencing** | LAV |
| HBEP | ☐ **Hemoglobinopathy Evaluation by HPLC** | LAV |

### THROMBOSIS RISK

| Code | Test | Specimen |
|---|---|---|
| FVR | ☐ **Factor V (F5) Leiden Mutation** | LAV |
| MTR | ☐ **Methylenetetrahydrofolate Reductase (MTHFR) mutation** | LAV |
| PTTR | ☐ **Prothrombin (20210) mutation** | LAV |

## NEOPLASTIC DISORDERS

| Code | Test | Specimen |
|---|---|---|
| KDSQ | ☐ **ABL Kinase Domain Mutations** | LAV/BM |
| BCRABL | ☐ **BCR/ABL Quantitative by PCR** | LAV/BM |
| CALR | ☐ **Calreticulin, Exon 9 Mutation Analysis** | LAV/BM |
| FLT3 | ☐ **FLT3 Mutations, Qualitative PCR** | LAV/BM |
| JAK2 | ☐ **Janus kinase 2 Mutation, Qualitative PCR** | LAV/BM |
| JMML | ☐ **JMML Associated Exon Panel** (NRAS, KRAS, PTPN11, CBL, SETBP1, SH2B3, NF1, JAK3, ASXL1) | LAV/BM |
| MGMT | ☐ **MGMT Promoter Methylation Assay** | FFPE slides |
| NPM1 | ☐ **NPM1 Mutation Detection** | LAV/BM |
| PMLR | ☐ **PML-RARA PCR, Qualitative** | LAV/BM |
| PMLQNT | ☐ **PML-RARA PCR, Quantitative** | LAV/BM |

## PHARMACOGENOMICS TESTS

| Code | Test | Specimen |
|---|---|---|
| IL28B | ☐ **IL28B Genotype** | LAV |
| UGT1A1 | ☐ **UDP Glucosuronosyltransferase 1A1** | LAV |

## OTHER TESTS

UCSF Medical Center

**CLINICAL LABORATORY - Outreach Testing Services**

Phone (415) 353-4122 Fax (415) 514-6373

Billing Questions: (415) 353-4745

**UCSF Use Only**

Acct #: ____________________

# INSTITUTIONAL ACCOUNT FORM

**BILLING POLICY: UCSF Clinical Laboratories is unable to bill patients directly or accept any personal insurance plans from outpatients that are not seen at the UCSF Medical Center. An institution account must be established by referring institution *prior* to sending sample.**

To establish an account, please complete the required information below and fax to our office at ***415-514-6373.*** An account # will be assigned and an itemized invoice will be sent to the referring institution when the test has been completed.

## INSTITUTION INFORMATION

INSTITUTION NAME ____________________

ORDERING PHYSICIAN NAME ____________________

DEPARTMENT/DIVISION ____________________

EMAIL ____________________

ADDRESS ____________________

**PHONE (for specimen questions)** ____________________

CITY/STATE/ZIP ____________________

**FAX (For faxing Lab Results)** ____________________

## BILLING CONTACT/ADDRESS

NAME ____________________

ADDRESS ____________________

PHONE ____________________

ADDRESS ____________________

FAX ____________________

CITY/STATE/ZIP ____________________

EMAIL ____________________

## GUARANTOR/AUTHORIZED SIGNATURE

SIGNATURE ____________________ PRINT NAME ____________________ DATE ____________

## For INTERNATIONAL Samples Only

For **INTERNATIONAL SAMPLES** (outside US), prepayment is required by our Laboratory. Please contact our Laborartory to make arrangements.

***PLEASE FAX COMPLETED FORM TO (415) 514-6373, Attn:*** *Cathy Figert*

***THANK YOU***

To: Physicians, Nurse Practitioners and other Healthcare Professionals

From: Edward Thornborrow, MD
Medical Director
UCSF Clinical Labs

RE: Facsimile Verification

You have requested that Lab Reports be faxed to you. These reports are considered Protected Health Information (PHI) as defined by HIPAA. Therefore, the Clinical Labs is required to obtain your verification that you accept receipt of PHI by FAX and have complied with the HIPAA regulations regarding the security of your FAX machine; its location, access and use.

Please read the attached document (page 2), filling in the requested information. FAX the form to our Relay Center staff (415) 353-4468. We will keep the signed form on file and will honor your future requests for facsimile transmission of PHI. It will be your responsibility to maintain your FAX security.

Your FAX number will be valid approximately 5 working days from the time we receive your signed Facsimile Verification form.

Please phone the Relay Center staff (415 353-1667) if you have any questions.

**UCSF CLINICAL LABORATORIES**

# FACSIMILE VERIFICATION FORM

The undersigned Client hereby authorizes UCSF Clinical Laboratories to send Protected Health Information (PHI) as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA, 45 C.F.R. Parts 160-64), to the following facsimile phone number to the extent such transmission is determined by UCSF Clinical Labs to be a necessary component of the professional business relationship between UCSF Clinical Labs and the Client:

Practice/Clinic
Facsimile number(s):_______________________________________________________
(List all facsimile numbers to which UCSF Clinical Lab Results may be transmitted).

Client represents to the UCSF Clinical Labs that Client has implemented appropriate policies and procedures, including physical safeguards, to ensure that the location of, access to and use of Client's facsimile machine complies with state and federal laws and regulations controlling the privacy of PHI including, but not limited to, HIPAA.

This Authorization will remain valid until revoked or changed by Client. To change its facsimile number(s), or to revoke this Authorization, Client must provide written notice to UCSF Clinical Labs at least five days prior to the implementation of the requested change or revocation. Notices may be faxed to UCSF Clinical Labs, Relay Center: (415) 353-4468, or mailed to UCSF Medical Center, Clinical Laboratories, Attn. Laboratory Director, Box 0100, 505 Parnassus, San Francisco, CA, 94143.

Practice/Clinic: _________________________________________________________________

Practice/Clinic Address:_______________________________________________________________

_________________________________________________________________________________

Practice/Clinic Rep. Signature:_______________________________________________

Practice/Clinic Rep. Printed Name:____________________________________________

Practice/Clinic Rep. Title/Position:____________________________________________

Practice/Clinic Phone Number:___________________________________________

PLEASE SIGN AND FAX A COPY OF THIS FORM TO THE ATTENTION OF:

UCSF RELAY CENTER STAFF: 415-353-4468