

CLINICAL LABORATORY

OUTREACH SERVICES

Customer Service 415-353-4645

Billing Information 415-353-4745

SHIP TO: UCSF Clinical Laboratories
 Attn: Outreach Processing
 185 Berry Street, Suite 290
 San Francisco, CA 94107

PATIENT INFORMATION

Last Name		First	M.I.
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		
Patient or Sample ID#		Institutional Account #	

SPECIMEN INFORMATION

Collection Date	Type of Specimen <input type="checkbox"/> Serum <input type="checkbox"/> Urine <input type="checkbox"/> Product of Conception <input type="checkbox"/> Plasma <input type="checkbox"/> CSF Tissue Origin: _____ <input type="checkbox"/> Whole Blood <input type="checkbox"/> CVS <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Amniotic Fluid Weeks Gestation: _____		
Collection Time			

CLIENT / BILLING INFORMATION

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

Institution Name	Ordering Physician/Contact Person	Telephone	Fax
Department or Division	Genetic Counselor	Telephone	Fax
Address	Billing Contact	Telephone	Fax
City, State, Zip	Billing Address (if different)	City, State, Zip	
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.		Indication For Testing / Comments / Special Request:	
Physician/Provider Signature: _____ Date: _____			

MOLECULAR DIAGNOSTICS

GENETICS STUDIES Tel: 415-353-1524

Thalassemia Testing ATHL <input type="checkbox"/> Alpha Thalassemia (common deletions) BTHL <input type="checkbox"/> Beta Thalassemia (common mutations) BGSQ <input type="checkbox"/> Reflex to Beta-Globin DNA Sequencing (if common mutations testing is negative)	IMPORTANT FOR RESULTS INTERPRETATION. Please provide requested information below. Hb A = _____ % Hb F = _____ % Iron = _____ µg/dL MCV = _____ fL Hb A2 = _____ % Other Hb = _____ % Ferritin = _____ µg/dL Ethnicity: _____ Check if testing is desired for: HBEP <input type="checkbox"/> Hemoglobin Quantitation by HPLC	Recent Transfusion History:
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|--|--|---|
| BCRABL <input type="checkbox"/> BCR/ABL Quantitative by PCR | FTD <input type="checkbox"/> Frontotemporal Dementia | MCC <input type="checkbox"/> Maternal Cell Contamination Analysis
(Requires mother & fetus samples) |
| BRCA <input type="checkbox"/> BRCA1 & BRCA2 Common Mutations
(Please call 415-353-1524 for specific instructions. Requires genetic counseling.) | HBCS <input type="checkbox"/> Unstable Hemoglobins
(Constant Spring, Pakse, Quong Sze) | MCAD <input type="checkbox"/> Medium chain Acyl Co-A
Dehydrogenase Deficiency |
| CNXN <input type="checkbox"/> Nonsyndromic Deafness (Connexin 26) | HHEM <input type="checkbox"/> Hereditary Hemochromatosis | PWA <input type="checkbox"/> Prader-Willi / Angelman |
| POLT <input type="checkbox"/> CBAVD (CFTR Intron 8 poly (T)) | INVN <input type="checkbox"/> Hemophilia A (inversion mutation) | TRM <input type="checkbox"/> Thrombosis Risk Mutations
(Includes Factor V Leiden / MTHFR/ Prothrombin) |
| MCFM <input type="checkbox"/> Cystic Fibrosis Mutation Analysis | HUNT <input type="checkbox"/> Huntington's Disease
(Please call 415-353-1524 for specific instructions. Requires genetic counseling.) | |
| FRX <input type="checkbox"/> Fragile X by DNA Analysis | | |

INFECTIOUS AGENTS

Tel: 415-353-1268

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|---|--|
| P344 <input type="checkbox"/> Bordetella Pertussis by PCR | P702 <input type="checkbox"/> Chlamydia Trachomatis DNA Detection |
| HIVB <input type="checkbox"/> HIV-1 RNA by bDNA Quant | HPV <input type="checkbox"/> Human Papilloma Virus High-Risk DNA Types |
| HCVB <input type="checkbox"/> HCV RNA by bDNA Quant | HCVG <input type="checkbox"/> HCV Genotyping |
| HCVTMA <input type="checkbox"/> Reflex to more sensitive assay if negative | HCVB <input type="checkbox"/> Quantitative HCV
(Lab will order Quantitative HCV test, if that has not been done in last 90 days.) |
| <input type="checkbox"/> Omit Reflex | |

MOLECULAR PATHOLOGY

Tel: 415-353-7241

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| UROV <input type="checkbox"/> UroVysion FISH (bladder cancer) |
| ERBB2 <input type="checkbox"/> HER-2/neu FISH (breast cancer) |
| <input type="checkbox"/> 1p19q Deletions FISH |
| <input type="checkbox"/> Melanoma Chromosome Alterations
by Comparative Genomic Hybridization |