MOLECULAR GENETIC TESTING

UCSF Medical Center

☐ **UCSF Medical Center**
San Francisco, CA

☐ **UCSF/Mount Zion Medical Center**
San Francisco, CA
(check hospital location)

CLINICAL LABORATORIES

400-0006 (Rev. 09/07) WorkflowOne

L
B
SS
GL
R
F
NL

☐ VPO ☐ HS

___ ___ ___TECH CODE

RECEIVE	ENTER
LABEL	ALIQUOT

SPECIMEN COLLECTION
Date: ____________________ Time (24 hour clock):________________

M.D. # ___ ___ ___ ___ ___ ATTENDING PHYSICIAN'S NAME (PRINT)

M.D. # ___ ___ ___ ___ ___ ORDERING PHYSICIAN'S NAME (PRINT)

M.D. # ___ ___ ___ ___ ___ COPY TO NAME (PRINT)

CLINICAL INFORMATION

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

BUDGET ACCT. NO.:

MEDICAL NECESSITY AND ICD-9 CODES (Required for outpatients only)

Medicare (and, increasingly, other insurers) will only pay for services that are reasonable and necessary for the diagnosis and treatment of the patient. The physician must specify an ICD-9 diagnostic code to indicate the medical necessity of ***each*** test requested. Medicare and other carriers may not pay for screening tests or tests that are not FDA-approved. If there is reason to believe that a carrier will not pay for a test, the patient should be informed and asked to sign an Advanced Beneficiary Notice (ABN - Attach to requisition) indicating acceptance of responsibility for the cost of the test if the carrier denies payment. Write the ICD-9 diagnosis code(s) for this patient in the numbered spaces below, then check off the tests desired.

1. ________________ **2.** ________________ **3.** ________________ **4.** ________________ **5.** ________________

REQUIRED FOR ALL NON-NEOPLASTIC TESTS

As the ordering provider, I certify that the patient has been appropriately informed of the benefits and limitations of this testing. Genetic counseling has been offered and informed consent obtained.

Note: Genetic counseling is REQUIRED prior to BRCA and Huntington's presymptomatic testing. Please specify the name of individual who provided this counseling: ______________________________

Signature ______________________________

Date ___ / ___ / ______

In addition to EDTA whole blood most genetic tests listed here can also be performed on Amniotic fluid, CVS samples or cultured cells.

THALASSEMIA & HEMOGLOBINOPATHY TESTING

HbA ______% HbF ______% HbA2 ______% Other Hb _______%

MCV ______fl RBC______x10(9)/L Fe______ μg/dL

Ferritin______ μg/dL Date of last transfusion: _______________

HBEP		Hemoglobinopathy evaluation by HPLC (Recommended if not already done)	LAV
ATHL		Alpha Thalassemia (Common deletions)	LAV
HBCS		Alpha Thalassemia Point Mutations (HbCS, Hb Quong Sze, Hb Pakse)	LAV
BTHL		Beta Thalassemia (Common Mutations, Incl HbS, HbC & HbE)	LAV
BGSQ		Reflex to Beta-Globin DNA Sequencing (if common mutation testing is **negative**)	LAV

OTHER INHERITED DISORDERS

For prenatal samples we recommend additionally submitting a sample of EDTA whole blood from the mother and ordering MCC below.

MCC		Maternal Cell Contamination	Maternal LAV
BRCA		BRCA1 & BRCA2 (Common Mutations)	LAV
MCFM		Cystic Fibrosis Mutation Analysis	LAV
POLT		Cystic Fibrosis CBAVD Poly T Mutation	LAV
FRX		Fragile X	LAV
FTD		Frontotemporal Dementia	LAV
HHEM		Hereditary Hemochromatosis	LAV
INVN		Hemophilia A Inversion	LAV
HUNT		Huntington's Disease	LAV
MCAD		Medium chain Acyl-CoA Dehydrogenase	LAV
CNXN		Non-syndromic Deafness (Connexin 26)	LAV
PWA		Prader-Willi / Angelman	LAV
TRM		Thrombosis Risk Mutations (FV Leiden, MTHFR, Prothrombin)	LAV

NEOPLASTIC DISORDERS

BCRABL		BCR/ABL Quantitative PCR	LAV, Marrow
ERBB2		HER-2/neu FISH (Breast cancer)	Tissue block
UROV		UroVysion FISH (Bladder cancer)	Urine
CGHMEL		Melanoma CGH	Tissue block
		1p19q (Neuropath)	Tissue block
		T cell clonality	LAV, Tissue block
		B Cell clonality	LAV, Tissue block

OTHER TESTS