MOLECULAR DIAGNOSTIC LABORATORY
Barnes-Jewish Hospital, Institute of Health
425 South Euclid Avenue
Room 5970, Mailstop #90-28-344
St. Louis, MO 63110
(314) 454-8685; (314) 454-7601; FAX (314) 454-7616
URL: http://pathology.wustl.edu/patientcare/moldiagnostic.php

Request For DNA Studies
MEDICAL GENETICS

COLLECTION INFORMATION: ☐ AM ☐ PM

DATE ______________ TIME ______________ INITIALS ____________

ACCOUNT INFORMATION

NAME

ADDRESS

CITY STATE ZIP

PHONE

FAX

ORDERING PHYSICIAN

SECOND REPORT TO

ACCOUNT	PATIENT ACCT.	RESEARCH ACCT.

THIS SECTION FOR LAB USE ONLY

PATIENT ID }	NO. SPEC RECEIVED }	REGISTERED BY }	VERIFIED BY }

PATIENT INFORMATION

PATIENT LAST NAME OR ID#	FIRST	DOB	SEX

RACE (see back)	ETHNICITY (see back)	DIAGNOSIS CODE	SSN

PATIENT'S ADDRESS	CITY	STATE	ZIP	PHONE

BILLING INFORMATION } **BILL TO:** ☐ ACCOUNT ☐ PATIENT ☐ INSURANCE ☐ RESEARCH ACCT.

☐ Medicare ID #__________________ ☐ Medicaid ALPHA Code_____________ ☐ CARE PARTNERS ☐ GHP ☐ PARTNERS HMO ☐ OTHER______________

INSURANCE CO.	I.D.#
ADDRESS	GRP.#
INSURED NAME (IF NOT PATIENT)	PLAN NAME

NOTE TO PHYSICIAN: When seeking payment from Medicare or Medicaid, Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient, for instance, Medicare does not cover routine screening, testing that is "investigative" or research use only, testing with quantity limits.

Laboratory Use Only:

Specimen Condition: ____

Specimen Number: ____

Date Received: __________________________ Time Received: __________________

Tube Type:
☐ EDTA
☐ ACD
☐ OTHER: __________________________

For Children: Father's Name: ______________________________ City: ______________________________

Mother's Name: ______________________________ State: ______________ Zip Code: __________

Diagnostic Test:
☐ Fragile X Syndrome
☐ Fragile X-Associated Tremor & Ataxia Syndrome FXTAS
☐ Factor 5 Leiden (FVL) Mutation
☐ Prothrombin (Factor 2) Mutation
☐ MTHFR C677T Mutation

Reason for Study: ☐ Diagnostic Testing ☐ Carrier Detection ☐ Prenatal Diagnosis ☐ Routine ☐ STAT

☐ Has genetic counseling by an authorized person been offered? (5946, 5953 exempted)

☐ Has informed consent been obtained from the consultant and/or guardian?

☐ Has genetic counseling by an authorized person been offered?

For CF Study Only: Ethnic Origins: Father: ______________________________ Mother: ______________________________

Please enter a short pedigree and any other clinical information below

Patient Demographic Information:

Race:	American Indian or Alaska Native	AI
	Asian	AS
	Black or African American	BL
	Native Hawaiian or other Pacific Islander	PI
	White	WH
	Unknown	UN
	Some other Race	SR
Ethnicity:	Hispanic or Latino	002
	Non Hispanic or Latino	003
	Unknown	004

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PATIENT INFORMATION

PATIENT LAST NAME OR ID# | FIRST | DOB | SEX

RACE (see back) | ETHNICITY (see back) | DIAGNOSIS CODE | SSN

PATIENT'S ADDRESS | CITY | STATE | ZIP | PHONE

BILLING INFORMATION } **BILL TO:** ☐ ACCOUNT ☐ PATIENT ☐ INSURANCE ☐ RESEARCH ACCT.

☐ Medicare ☐ Medicaid ☐ CARE PARTNERS ☐ PARTNERS HMO

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Patient Demographic Information:

Race:	American Indian or Alaska Native	AI
	Asian	AS
	Black or African American	BL
	Native Hawaiian or other Pacific Islander	PI
	White	WH
	Unknown	UN
	Some other Race	SR
Ethnicity:	Hispanic or Latino	002
	Non Hispanic or Latino	003
	Unknown	004

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BARNES JEWISH Hospital
BJC HealthCare

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Race:
- American Indian or Alaska Native .... AI
- Asian .... AS
- Black or African American .... BL
- Native Hawaiian or other Pacific Islander .... PI
- White.. WH
- Unknown.. UN
- Some other Race .... SR

Ethnicity:
- Hispanic or Latino 002
- Non Hispanic or Latino 003
- Unknown.. 004