JOHNS HOPKINS MEDICINE

Johns Hopkins Genomics
DNA Diagnostic Laboratory

General Requisition Form - Page 1

v052824

Referrer Information

Physician: | UPIN/NPI:

Genetic Counselor: | Email:

Institution:

Address:

Phone: | Fax:

Additional reports to:

Address:

Phone: | Fax:

Mandatory Signature

I have confirmed that the patient has consented for the testing ordered and that two matching identifiers are present on each page of this requisition.

Signature:

Date:

Patient Information (*two of these identifiers MUST also appear on the sample tube)

Legal Name* (Last): | (First):

Preferred Name (Last): | (First):

Date of birth* (mm/dd/yyyy): | Sex assigned at birth: | Gender:

Patient ID/MRN*:

Patient Address:

Billing Information (contact Billing Coordinator at 667-306-8282 prior to submitting)

Billing contact:

Phone: | Fax: | Email:

☐ Inpatient ☐ Referring Center ☐ MD Medicaid ☐ Self-pay ☐ Patient Insurance ☐ Medicare

Shipping Address: 1812 Ashland Ave, Sample Intake; Rm 245, Baltimore, MD 21205

Clinical Information

Patient Name:

DOB (mm/dd/yy):

Indication:

ICD Codes:

Please attach detailed medical records.

Ancestry

- [ ] Black, African American, or of African descent
- [ ] East Asian
- [ ] Hispanic, Latino/Latina/Latinx
- [ ] Native American, Alaska Native, First Nations
- [ ] Middle Eastern, Southwest Asian, North African
- [ ] Native Hawaiian, Pacific Islander
- [ ] South Asian
- [ ] Southeast Asian
- [ ] White
- [ ] Other: _____

Sample Information

Sample Type

Blood and saliva are not acceptable if the patient has:

- Received blood products <2 weeks before specimen collection. Exceptions are made for pRBC-only transfusions.
- Received an allogenic bone marrow or stem cell transplant. Cultured skin fibroblasts are the only accepted specimen type in this case.
- Active hematologic malignancy; cultured skin fibroblasts are the recommended sample type.

Contact the lab with specific questions or concerns.

Collection Date:

- [ ] Whole Blood
- [ ] Cord blood
- [ ] Extracted DNA
- [ ] Cleaned chorionic villi
- [ ] Saliva
- [ ] Cultured chorionic villi
- [ ] Cultured skin fibroblasts*
- [ ] Cultured amniocytes
- [ ] Other: _____

Isolation or extraction of nucleic acids must be performed in a CLIA-certified laboratory or a laboratory meeting equivalent (or more stringent) requirements as determined by the College of American Pathologists (CAP) and/or the Centers for Medicare and Medicaid Services (CMS).

Patient Informed Consent

I grant permission for Johns Hopkins Genomics to perform the genetic test listed on this form for me/my child. The results of genetic testing may be dependent upon the clinical information provided to the laboratory by my physician. The laboratory cannot guarantee turn-around-time. Risks and limitations of this test may include, but are not limited to, disclosure of unexpected family information (non-paternity, consanguinity), uninformative negative results, unexpected findings, and lab error. De-identified clinical or genetic information may be used for quality control purposes, research, and shared in public healthcare databases. Results will be released only to the providers authorized on the test requisition. I understand the benefits, risks, and limitations of this genetic testing.

Signature: **Date:**

Provider Alternate Consent

I, the health care provider requesting the above testing, have explained the benefits and drawbacks of genetic testing to the patient and have obtained verbal consent or an alternate written consent (please attach) to order the test indicated. I have confirmed that the patient has consented for the testing ordered and that two matching identifiers are present on each page of this requisition.

Signature: **Date:**

Patient Information

Patient Name: _____ _____ DOB: _____

Test Directory

Zoom Panels *(See website for full gene lists)*

- ☐ **CraniofacialZoom**
- ☐ **FancZoom**
- ☐ **HemeZoom**
  Subpanels available:
  - ☐ *Congenital dyserythropoietic anemia*
  - ☐ *Erythrocytosis*
  - ☐ *Erythropoietic porphyria*
  - ☐ *Hemoglobinopathy*
  - ☐ *Megaloblastic anemia*
  - ☐ *RBC enzymopathy/Hemolytic anemia*
  - ☐ *RBC membranopathy/Hemolytic anemia*
  - ☐ *Sideroblastic anemia*
  - ☐ *Other anemias*
- ☐ **Low Bone DensityZoom**
- ☐ **MarrowZoom**
- ☐ **NeuromuscularZoom**
  Subpanels available:
  - ☐ *Myopathy*
  - ☐ *Charcot-Marie-Tooth*
  - ☐ *Hereditary spastic paraplegia*
- ☐ **PulmZoom**
  Subpanels available:
  - ☐ *Mucociliary disorders*
  - ☐ *Interstitial lung disease*
  - ☐ *Pulmonary vascular disease*
- ☐ **RenalZoom**
  Subpanels available:
  - ☐ *CAKUT, ciliopathies, and tubulointerstitial diseases*
  - ☐ *Disorders of ion transport, nephrolithiasis, and nephrocalcinosis*
  - ☐ *Glomerular disease and complement genes*
- ☐ **SkeletalZoom**
- ☐ **Stickler22qZoom**
- ☐ **TeloZoom** *(does not include Telomere Length Testing)*

Targeted Variant(s)

Gene_____ c._____ p._____

Gene_____ c._____ p._____

Relationship to proband: _____

**Please attach copy of previous report and phenotypic information*

Prenatal Tests

- ☐ Maternal cell contamination study only
- ☐ Targeted variant(s)

Gene_____ c._____ p._____

Gene_____ c._____ p._____

Relationship to proband: _____

**Please attach copy of previous report*

Please ship samples to:

1812 Ashland Ave
Sample Intake; Rm 245
Baltimore, MD 21205

For sample specific requirements please visit our website.