Patient Name:_____
Identification Number: _____

UPMC LIFE CHANGING MEDICINE

GENETICS REQUISITION FORM (CYP2C19, CF, MCC, SMA)

PATIENT INFORMATION (*Please Print*):

First Name:	**MI:**	**Last Name**
Date of birth: (MM/DD/YYYY)	**MRN #:**	**Genetic Sex (Required):** ☐ M ☐ F ☐ Unk
	Gender Identity (Optional):	
Address		**City:**
State:	**Zip Code:**	**Phone:**

Ancestry (check all that apply):
☐White/Caucasian ☐ Black/African American ☐ Hispanic
☐ Asian ☐ Ashkenazi Jewish ☐ Eastern/Central Europe
☐ Western/Northern Europe ☐ Central/South American ☐ Middle Eastern ☐ Native American ☐ Other: (specify)_____

REFERRING PHYSICIAN INFORMATION (*Please Print*):

Physician:		
Address:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	
NPI#:		
Additional Report To:		**Fax:**
Other Medical Professional:		**Fax:**

SPECIMEN INFORMATION

A requisition form MUST accompany each specimen.

Date/Time of sample obtained
Date: _____ **Time:** _____:_____

☐ **Peripheral Blood in EDTA (5-6 mL)**
☐ **Saliva (*CFTR & SMN1* only)**
☐ **Extracted DNA: Source of Extracted DNA**
☐ **CVS** ☐ **Amniotic Fluid** ☐ **Peripheral Blood**

INFORMED CONSENT & STATEMENT OF MEDICAL NECESSITY

I affirm each of the following: I have provided genetic information to the patient and the patient has consented to genetic testing. This test is medically necessary for the diagnosis of a disease or syndrome. The result will be used in the patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein.

REQUIRED
Signature of Requesting Physician _____

INDICATION FOR STUDY:

Reason for Referral :	**ICD-10 Code(s):**

☐ **Diagnosis/Suspected diagnosis**
List clinical findings: _____
_____
_____

☐ **Carrier screening**
☐ **Positive family history**
Relationship to patient: _____
Gene variant(s) known in family: _____
☐ **Abnormal fetal ultrasound**
List findings: _____
_____
☐ **Other (list):** _____
Comments/ Special Instructions _____

TEST(S) REQUESTED:

☐ **CYP2C19 Genotyping**
☐ **Cystic fibrosis (*CFTR*)- carrier screen (145 variant panel)**
☐ **Cystic fibrosis (*CFTR)* targeted variant analysis**
Variant(s) to be analyzed: _____
☐ **Cystic fibrosis DNA Analysis, Fetus**
☐ **Maternal cell contamination (MCC)**
☐ **Spinal Muscular Atrophy (SMA)- carrier screen (*SMN1* dosage)**
☐ **Spinal Muscular Atrophy (SMA)- diagnostic test (*SMN1* dosage *& SMN2* dosage)**