DNA ANALYSIS REQUEST FORM FOR (laboratory name)_____

PATIENT LAST NAME	**FIRST NAME**	**MI**
DOB / /	Sex M F	Hospital/ID Number

REFERRING PHYSICIAN/GENETICIST

Name:_____

Address: _____

_____

_____

_____

Telephone: ( ) FAX: ( )

SIGNATURE: _____

PREVIOUS DNA STUDIES **YES NO (if YES, specify)**

Individual(s) studied: _____

Analysis performed: _____

Laboratory: _____

Approximate date of study: _____

ADDITIONAL FAMILY MEMBERS TO BE STUDIED **RELATIONSHIP**

1._____

2._____

INDICATION FOR TEST:

GENETIC DISORDER TO BE STUDIED

_____

ANALYSIS REQUESTED

☐ Carrier identification
☐ Diagnostic
☐ Genotype
☐ Prenatal diagnosis
☐ Presymptomatic/nonpenetrant identification
☐ Other _____.

INSURANCE INFORMATION

_____

_____

PLEASE INDICATE PEDIGREE

ETHNIC BACKGROUND (Important for Accurate Test Interpretation)

☐ NW European Caucasian ☐ Hispanic
☐ S European Caucasian ☐ African American
☐ Mixed European Caucasian ☐ Native American Indian
☐ Ashkenazic Jewish ☐ Other_____
☐ Other Jewish
☐ Asian

GENETIC COUNSELING

☐ CHECK if referring physician/geneticist will perform genetic counseling

PRENATAL INFORMATION

☐ Amniotic fluid specimen: _____ml.
☐ Chorionic villus sampling (CVS): _____mg.
☐ Other

LMP ____/____/____ Twin Gestation? Yes No
Date of U/S ___/___/___ Gestation by U/S ___/___/___
Sex of Fetus (if known) M F

BLOOD SPECIMEN INFORMATION

Time/Date of Sample Collection: _____

Number of EDTA (purple top) Tubes: 1 2 3 4 5 6

Approximate volume (must be at least 8 ml.) _____ml.

**** Please send this completed form with the specimen.*** **** Unlabeled specimens will not be processed.***