



Children's Hospital Colorado

Children's Hospital Colorado
Department of Pathology & Laboratory Medicine
Biochemical Genetics Lab Requisition
Phone (720) 777-6711
Fax (720) 777-7118

Specimen Shipping Address:
Children's Hospital Colorado
Clinical Laboratory - Room B0200
13123 E. 16th Ave
Aurora, CO 80045

Client

FAILURE TO COMPLETE BELOW FIELDS WILL DELAY RESULTS

PLEASE PROVIDE COMPLETE BILLING INFORMATION ON THE BACK OF THIS FORM

Contact Information

Ordering Institution Name, Ordering Institution Address, Ordering Provider (Last, First, and Middle Initial), Ordering Provider Phone, Result Contact Name, Result Phone, Result Fax

Patient Information

Last Name, First Name, Middle I, Birthdate (MM/DD/YYYY), Sex, Client Medical Record Number, Client Specimen Number, Diagnosis/ICD-10 Code

Specimen Information

Date Collected (MM/DD/YY), Time Collected (HHMM) AM / PM, Blood, Urine, Serum, Plasma, Stool, Nasal Wash, BAL, Swab Source & Site, Other

Test Information

Biochemical Genetics Testing

Amino Acids, Other, Enzyme Activity Assays, Mitochondrial Diagnostic Test Information

Mitochondrial Diagnostic Test Information

Please complete the clinical information portion on the back of this requisition

Blue native electrophoresis with in-gel activity staining, Mitochondrial respiratory chain enzyme assay, Glycine cleavage enzyme assay, Liver, Pyruvate dehydrogenase enzyme assay, Fibroblasts (L7085)

Tissue Source, Specimen Storage Prior to Shipment, Use of Antibiotics linezolid, macrolides, chloramphenicol in last week?

Additional Comments:

Specimen requirements and shipping and handling information can be found on our website at www.childrenscolorado.org/lab
By submitting this document you agree to the terms and conditions listed on our website



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General & Microbiology Lab Requisition
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Aurora, CO 80045

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Please do not send patient insurance. We bill clients only, referring provider will be held responsible for payment if no billing information is provided.

FAILURE TO COMPLETE WILL DELAY RESULTS

Bill To: [] Billing Facility and Address same as listed on page 1

Institution Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Billing Contact Information:

Name: _____

Email: _____

Phone: _____

Clinical Information (for Mitochondrial testing ONLY)

Please check all that apply

General, Brain, Eye, Hearing, Endocrine, Kidney, GI, Heart, Skin, Muscle, Laboratory Studies, Radiology, Recognized Syndromes, Previous Mito Investigations