

PATIENT INFORMATION	DIAGNOSTIC TESTS REQUIRED
Name: _____ Date of Birth: ___/___/___ Sex: M F Race: _____ Address: _____ _____ Zip: _____ Phone: (____) _____ Hospital/Source: _____ Inpatient Outpatient Hospital #: _____	Metabolic Studies: <input type="checkbox"/> Quantitative Amino Acids: <input type="checkbox"/> Urine (including screening for ketones and reducing Sugars) (82139) <input type="checkbox"/> Plasma (82139) <input type="checkbox"/> CSF (82139) <input type="checkbox"/> Organic Acids (GC/MS; urine) (83919)
REFERRING PHYSICIAN Name/Signature: _____ Address: _____ _____ Zip: _____ Phone: _____ Fax: _____ Send Additional Report To: _____	<input type="checkbox"/> Mucopolysaccharide Screen (urine): <input type="checkbox"/> Spot Test (83864) <input type="checkbox"/> Thin Layer Chromatography (10cc urine minimum) (84375) <input type="checkbox"/> Oligosaccharide Thin Layer Chromatography(urine)(84377)
PATIENT CLINICAL INFORMATION Reason for Referral/ICD9 Code: _____ <input type="checkbox"/> Dev. Delay/MR <input type="checkbox"/> On Medication: <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Anticonvulsants _____ <input type="checkbox"/> Seizures <input type="checkbox"/> Antibiotics _____ <input type="checkbox"/> Vomiting <input type="checkbox"/> Other _____ <input type="checkbox"/> Hyperammonemia <input type="checkbox"/> Special Diet: <input type="checkbox"/> Acidosis <input type="checkbox"/> MCT Supplement <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Other _____	<input type="checkbox"/> Carnitine (Free and Total) (LC/MS): <input type="checkbox"/> Plasma (82379) <input type="checkbox"/> Quantitative Methylmalonic Acid (LC/MS; plasma) (83921): <input type="checkbox"/> Other _____ Lysosomal Enzyme Studies: <input type="checkbox"/> Arylsulfatase A (Metachromatic Leukodystrophy) (82657) <input type="checkbox"/> α -Galactosidase A (Fabry Disease) (82657) <input type="checkbox"/> β -Galactosidase (GM1-Gangliosidosis) (82657) <input type="checkbox"/> Gallactosylceramide β -galactosidase (Krabbé Disease) (82657) <input type="checkbox"/> β -Glucosidase (Gaucher Disease) (82963) <input type="checkbox"/> β -Hexosaminidase (Tay-Sachs & Sandhoff Disease) (83080)
SPECIMEN INFORMATION <input type="checkbox"/> Plasma <input type="checkbox"/> Urine <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Heparinized Whole Blood <input type="checkbox"/> Skin Fibroblasts <input type="checkbox"/> Other _____ Date/Time Collected: _____	Other Enzymes Studies: <input type="checkbox"/> Biotinidase (biotinidase Deficiency, serum) (82261) <input type="checkbox"/> Disaccharidase Panel (82657x5) (includes: lactase, maltase, sucrose, palatinase & glucoamylase)
BILLING INFORMATION <input type="checkbox"/> Bill Referring Lab: _____ _____ Address: _____ _____ Phone: _____ Fax: _____	Test for Galactosemia: <input type="checkbox"/> Galactose-1-Phosphate (quantitative)* (84378,84311) *PLEASE CALL LAB BEFORE COLLECTING SPECIMENS FOR THESE TESTS. <div style="text-align: right;">Revised 12/01/17</div>