

Submit

Reset Form

**ADVANCED DIAGNOSTICS LABORATORY**

1935 Medical District Drive, MC B1.06

Dallas, TX 75235

Phone: (214) 456-2320, option 1

Fax: (214) 867-9453

Email: ADXLab@childrens.com

Jason Y. Park, M.D., Ph.D., Director

Midori Mitui, Manager

ADX Lab Request

1. Fill out page 1 and 2 of the form.
2. Send the form to the laboratory by clicking the "Submit" button.
3. Print the form and include a copy with the sample.

LABORATORY REQUISITION FORM

Patient Name: _____ Date of Birth: _____
 (Last) (First) (Middle)

Hospital MRN: _____ Ethnicity: _____ Gender: _____

Sample Information

Date of Collection: _____ ☐ Blood/Purple Top (min 1 mL) ☐ FFPE Block ☐ Other: _____

Specimen ID: _____ ☐ DNA* ☐ RNA* ☐ FFPE Scrolls**

*DNA or RNA isolation must be performed in a CLIA-certified (or equivalent) laboratory. Consult the laboratory for minimum requirements

**Oncology Fusion Seq: FFPE scrolls 10 µm thick, 2 tubes (up to 2 mm3 tissue each); minimum lesional cell content: 10%

**Oncology Microarray: FFPE scrolls 10 µm thick, 2 tubes (up to 2 mm3 tissue each); minimum lesional cell content: 40%

**H. pylori: FFPE scrolls 10 µm thick, 2 tubes (up to 2 mm3 tissue each); minimum number of organisms on a single 5-micron IHC section: 48

Provider Information/Referring Institution

Provider: _____ Institution: _____

Address: _____ City: _____ State: _____ Zipcode: _____

Phone: _____ Fax: _____ Email Address: _____

Billing Contact (if different): _____ Email Address: _____

Testing services are only available as client billed services. Insurance is not directly billed.

Patient Information

Summarize history or attach clinic note:

Family history or attach pedigree:

Previous test history (include copy of previous test (results):

Family Member Testing

☐ Targeted Seq Analysis ☐ VUS Familial Testing

Gene: _____

Variant: _____

Summarize pertinent history:

	ADVANCED DIAGNOSTICS LABORATORY Phone: (214) 456-2320, option 1 Fax: (214) 867-9453 Email: ADXLab@childrens.com Jason Y. Park, M.D., Ph.D., Director Midori Mitui, Manager	SHIP TO Advanced Diagnostics Laboratory Children's Health 1935 Medical District Drive, MC B1.06 Dallas, Texas 75235
Patient Name: _____ (Last) _____ (First) _____ (Middle)		
Molecular Genetic Test Menu		
Single Gene Tests		Multi-Gene Tests
☐ Fragile X Chromosome	☐ Oncology Fusion Seq v2 Lesional cell content (REQUIRED): _____	
☐ HBB Gene Sequencing	☐ Pulmonary Genes Seq v4	
☐ H. pylori Genotypic Analysis for Susceptibility	☐ Neurodevelopmental Genes Seq	
☐ Targeted CNV PCR	☐ Immune Dysregulation Genes Seq	
☐ Targeted Fusion PCR	☐ Pancreatitis Genes Seq v2	
☐ Miscellaneous: _____	☐ Epilepsy Genes Seq v2 _____	
☐	☐ Whole Exome Sequencing - Proband ☐ Rapid ☐ Routine	
☐	☐ Whole Exome Sequencing - Trio ☐ Rapid ☐ Routine	
☐	Name of Additional Family Member: _____	
☐	Relationship to Patient: _____	
☐	Name of Additional Family Member: _____	
☐	Relationship to Patient: _____	
Cytogenomic Tests		☐ Whole Exome Sequencing - Duo ☐ Rapid ☐ Routine
☐ CytoScan Dx Chromosomal Microarray	Name of Additional Family Member: _____	
☐ Neuroblastoma-Targeted Oncology Microarray Lesional cell content (REQUIRED): _____	Relationship to Patient: _____	
☐ Wilms Tumor-Targeted Oncology Microarray Lesional cell content (REQUIRED): _____		
☐ Oncology Chromosomal Microarray, Tumor FFPE Lesional cell content (REQUIRED): _____	☐ Whole Exome Sequencing Reanalysis (No Specimen Required)	