



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 Email button.
3. Print the form and include the copy with the sample.

LABORATORY REQUISITION

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

Hospital MRN: Ethnicity: Gender:

Sample Information

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

Specimen ID: DNA* FFPE Scrolls**

*DNA isolation must be performed in a CLIA-certified (or equivalent) laboratory. Consult the lab for min DNA requirements.
**Oncology Fusion Seq: FFPE scrolls with a thickness of 10 µm, in two separate tubes, each containing up to 2 mm3 of tissue. Minimum lesional cell content required: 10%.
**H. pylori test: FFPE scrolls with a thickness of 10 µm, in two separate tubes, each containing up to 2 mm3 of tissue; min. 48 organisms on a single 5-micron IHC section.

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:

Empty box for patient history/clinic note

Family history or attach pedigree:

Empty box for family history/pedigree

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

Empty box for previous test history

Family Member Testing

Target Analysis OR VUS Familial Testing

Gene:

Variant:

Summarize pertinent history:

Empty box for family member testing history



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SHIP TO

Advanced Diagnostics Laboratory
 Children's Health
 1935 Medical District Drive, MC B1.06
 Dallas, Texas 75235

Patient Name: _____ (Last) _____ (First) _____ (Middle)

Molecular Test Menu

Single Gene Tests		Multi-Gene Tests	
<input type="checkbox"/>	Fragile X Chromosome	<input type="checkbox"/>	Oncology Fusion Seq, 173 Genes Lesional cell content (REQUIRED): _____
<input type="checkbox"/>	HBB Gene Sequencing	<input type="checkbox"/>	Pulmonary Genes Seq v4
<input type="checkbox"/>	H. pylori Genotypic Analysis for Susceptibility	<input type="checkbox"/>	Miscellaneous: _____
<input type="checkbox"/>	Targeted CNV PCR	<input type="checkbox"/>	Whole Exome Sequencing Proband Option: <input type="checkbox"/> Rapid <input type="checkbox"/> Routine
<input type="checkbox"/>	Targeted Fusion PCR	<input type="checkbox"/>	Whole Exome Sequencing Trio Option: <input type="checkbox"/> Rapid <input type="checkbox"/> Routine Name of additional Family member: _____ Relationship to Patient: _____ Name of additional Family member: _____ Relationship to Patient: _____
<input type="checkbox"/>	Miscellaneous: _____		
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
Cytogenomic Tests		<input type="checkbox"/>	Whole Exome Sequencing Duo Option: <input type="checkbox"/> Rapid <input type="checkbox"/> Routine Name of additional Family member: _____ Relationship to Patient _____
<input type="checkbox"/>	CytoScan Dx Chromosomal Microarray	<input type="checkbox"/>	Whole Exome Sequencing re-analysis (no specimen required)
<input type="checkbox"/>			
<input type="checkbox"/>			