



Children's National

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Washington, DC 20012
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DIVISION OF LABORATORY MEDICINE

LABORATORY TEST REQUISITION #5 (MOLECULAR)

* Requesting Physician: _____
* Requesting Physician Signature: _____; Pager #: _____
Service: _____; Collection Date & Time: _____ (Date); _____ (Time)
* Collected By: _____ * Specimen Source _____

*** ICD10 DIAGNOSIS CODE(S) - MANDATORY:**

* Insurance Authorization (Circle One): **NOT REQUIRED** or **APPROVED**

* CPT Code(s) - Targeted Genome Panels Only:

If authorization was granted, please provide authorization number and time frame:

NGS Germline Testing (Single and Multi-Gene Panels)

ARCP	BearSeq Comprehensive Arrhythmia and Cardiomyopathy Panel
CONX	BearSeq Comprehensive Connective Tissue Panel
CHLP	BearSeq Comprehensive Hearing Loss Panel
NATP	NAT Panel
TGP≥15G	Targeted Genome Panel ≥ 15 Genes (limit ≤250 genes)
TGP<15G	Targeted Genome Panel < 15 Genes
	*Targeted Genome Panel: Please verify gene availability prior to ordering. Please email the gene list to LabMed_Genetic_Counselors@childrensnational.org

Whole Exome Sequencing Orders

BWET	BearSeq Whole Exome Sequencing- Trio
BWED	BearSeq Whole Exome Sequencing- Duo
BWEP	BearSeq Whole Exome Sequencing- Proband
BWETR	BearSeq Whole Exome Reanalysis- Trio
BWEDR	BearSeq Whole Exome Reanalysis- Duo
BWEPR	BearSeq Whole Exome Reanalysis- Proband

Family Member Whole Exome Sequencing

	BWEFM	Family Member Whole Exome Sequencing, must include the following information:
		Proband's Name:
		Proband's MRN:
		Relationship to Proband: _____ Affected OR Unaffected (Circle One)
	BWEFM	Family Member Whole Exome Sequencing, must include the following information:
		Proband's Name:
		Proband's MRN:
		Relationship to Proband: _____ Affected OR Unaffected (Circle One)

Family Member Whole Exome Sequencing Reanalysis

	BWEFMR	Family Member Whole Exome Sequencing Reanalysis must include the following information:
		Proband's Name:
		Proband's MRN:
		Relationship to Proband: _____ Affected OR Unaffected (Circle One)
	BWEFMR	Family Member Whole Exome Sequencing Reanalysis must include the following information:
		Proband's Name:
		Proband's MRN:
		Relationship to Proband: _____ Affected OR Unaffected (Circle One)

Whole Exome Sequencing Information (MANDATORY)

Consented to Receive Secondary Findings?

YES
NO

HPO Terms (List at least 1)

**PLACE PATIENT LABEL
HERE**

Name: _____
DOB: _____
MRN: _____
* Insurance Company (MANDATORY): _____

Pharmacogenomic Tests

THIOPS	TPMT Genotyping
Other Molecular Tests	
BSPOP	BearSeq PedsOnc Panel
CNSTM	Methylation, DNA Methylation Profiling for CNS Tumor
PBMTNC	Engraftment without Cell Selection Post BMT
PBMTC	Engraftment with Cell Selection Post BMT
PTCHD	Chimerism- Pre BMT (Donor)
PTCHR	Chimerism- Pre BMT (Recipient)
CMA	Chromosomal Microarray
DNEXT	DNA Extraction
FRAGX	Fragile X
FVL	Factor V Leiden Mutation Testing
FIIM	Prothrombin Gene Mutation (G20210A)

Parental Testing

CPAREN	Chromosomal Microarray Parental Testing, must include the following information:
	Child's Name:
	Child's MRN:
NPAREN	NGS Parental Testing, must include the following information:
	Child's Name:
	Child's MRN:

Name & Number of Primary Contact (physician, genetic counselor, etc.)

Clinical Indication & Family History

Targeted Genome Panel (Write or Attach Gene List Below)

* Required Field

Questions can be addressed by contacting LabMed_Genetic_Counselors@childrensnational.org