### DNA TESTS FOR GENETIC DISEASES

- Fragile X Syndrome (Reflex Southern Blot if needed)
- Prader-Willi/Angelman Syndrome (MS-MLPA)
- Myotonic Dystrophy, DM-1 (Reflex Southern Blot if needed)
- Huntington Disease (CONSENT FORM REQUIRED)
- Cystic Fibrosis (CFTR)
- Deletion/Duplication Analysis
- Mutation Panel with Reflex Sequencing
- ACADM Mutation analysis for MCAD Deficiency
- Genotyping - K304E and Y42H
- Sequencing
- MUTYH
- Mutation Panel with Reflex Sequencing
- ACADM Mutation analysis for MCAD Deficiency
- Genotyping - K304E and Y42H
- Sequencing
- Sequencing - Exons 8/17
- WT1 expression level analysis
- Quantitative – Diagnostic
- Quantitative – Minimal Residual Disease

### DNA TESTS FOR MOLECULAR CARDIOLOGY

- QT Stephens Panel (KCNQ1, KCNH2, SCN5A, KCNQ1, KCN2, KCNJ1)
- Familial Atrial Fib Panel (KCNQ1, SCNSA, KCNE2, KCNJ2, KCNAS, LMNA)
- Or select by individual Gene(s):
  - KCNE2
  - KCN1
  - SCNSA
  - KCNE1
  - KCNO1
  - KCNJ2
  - KCNAS
  - LMNA

### NEXT GENERATION SEQUENCING FOR MOLECULAR CARDIOLOGY

- NGS Cardiomyopathy (CMP) Panel-62 genes
- NGS HCM Panel - 18 genes
- Reflex NGS CMP-62 genes
- NGS DCM/LVNC Panel - 33 genes
- Reflex NGS CMP-62 genes
- NGS ARVC Panel - 8 genes
- Reflex NGS CMP-62 genes
- NGS Thoracic Aortic Aneurysm Dissection (TAAD) Panel-18 genes
- NGS Noonan Spectrum Disorders/RASopathies Panel -13 genes

### DNA TESTS FOR MOLECULAR ONCOLOGY

- FL73 PCR analysis of ITD and D835
- NPM1 PCR analysis of insertion mutation in exon 12
- EEBPA Sequencing analysis of the entire coding region
- PML/RARA t(15;17) PCR analysis of the transcripts:
  - Qualitative – Diagnostic
  - Quantitative – Diagnostic & Reflex Quantitative
  - Quantitative – Minimal Residual Disease
  - KIT mutation analysis
  - Genotyping – D816V
  - Sequencing – Exons 8/17
  - WT1 expression level analysis
  - Qualitative – Diagnostic
  - Quantitative – Minimal Residual Disease

### DNA TESTS FOR IDENTITY DETERMINATION

- Maternal Cell Contamination Studies:
  - Maternal Sample
  - Peripheral Blood
  - Buccal Swab
  - Other
  - Fetal Sample
  - Cord Blood
  - POC
  - Umbilical Blood
  - AF

### CONSENT FORM REQUIREMENTS

- Specimen Requirements:
- Shipping Instructions:
- Cancellation Policy:

### BILLING INFORMATION

- Lab Use
- Informed Consent Form Received (if applicable):
  - YES
  - NO
- Date Received

### Demographic Sheet

<table>
<thead>
<tr>
<th>Column</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Relation</td>
<td></td>
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<tr>
<td>MRN</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
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<tr>
<td>City, State, Zip</td>
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<tr>
<td>Phone/Fax</td>
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<tr>
<td>Date Collected</td>
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<tr>
<td>Collected By</td>
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</tr>
<tr>
<td>Volume</td>
<td></td>
</tr>
<tr>
<td>Specimen Type</td>
<td>AF, CVS, BL, BM, DNA, Other:</td>
</tr>
<tr>
<td>Date Received</td>
<td></td>
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<tr>
<td>Received By</td>
<td></td>
</tr>
<tr>
<td>Tube(s)</td>
<td></td>
</tr>
<tr>
<td>Vol</td>
<td></td>
</tr>
</tbody>
</table>

### Molecular Genetics Diagnostic Laboratory

**SHIPPING INSTRUCTIONS**: Tube Station #829 or Indiana University Department of Medical and Molecular Genetics

550 University Blvd, UH-AOC 6029, Indianapolis IN. 46202-5255 Phone: (317) 944-7597 Fax: (317) 944-4384

### Divisional website

http://geneticslab.medicine.iu.edu/


**INITA #**: 15D0647198  **CAP#:** 167830  **Hours of Operation**: Monday through Friday, 8:00am to 5:00pm
**CANCELLATION POLICY**

Cancellation of test orders must be received within **48 hours** of sample receipt in the laboratory. Testing scheduled for STAT/priority processing cannot be canceled after sample receipt due to adjusted lab processing.

To cancel testing, call 317-944-7597 within 48 hours of sample receipt.

**Note:** A handling fee may be assessed for initial processing of the sample prior to test cancellation.

To revise requested testing, call 317-944-7597 to determine the status of the patient’s sample in lab and discuss available options.

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**Specimen Requirements**

*Please label all containers with patient name, MRN, and date of collection. Attach a completed requisition form, including diagnosis with the sample. Use sterile technique and close all containers tightly. Samples should be delivered to the lab on the same day of collection. If sample is collected after business hours or missed transportation pick-up, please keep sample in the refrigerator or at room temp and deliver to the lab as soon as possible on the next business day. Samples from off site should be shipped at room temperature for overnight delivery directly to the lab address listed at the top front of this requisition form. In hot weather, a cool pack may be enclosed. DO NOT FREEZE.*

**Ship Specimens to:** Molecular Genetics Diagnostic Laboratory, Indiana University Department of Medical and Molecular Genetics, 550 University Blvd, UH-AOC 6029, Indianapolis IN. 46202-5255.

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Blood</td>
<td>2-6 mL of whole blood in EDTA (purple top tube) for routine tests. Ship overnight at room temperature. In hot weather a cool pack may be enclosed. Do not freeze blood.</td>
</tr>
<tr>
<td>DNA</td>
<td>Send the DNA specimen in a screw cap tube at least 5 μg of genomic DNA at a concentration of at least 20 ng/μl. Ship overnight at room temperature. In hot weather a cool pack may be enclosed. Note: The sensitivity of our deletion/duplication assay may be reduced when DNA is extracted by an outside laboratory. For best results, please provide a fresh blood sample for this testing.</td>
</tr>
<tr>
<td>Bone Marrow</td>
<td>2-5 mL in purple top EDTA tube (preferred) or yellow top citric acetate tube. Ship overnight at room temperature. In hot weather a cool pack may be enclosed.</td>
</tr>
<tr>
<td>Cell Culture</td>
<td>Ship two T25 flasks of confluent cells or more, sterile, tissue of origin information included. Ship overnight at room temperature. In hot weather a cool pack may be enclosed.</td>
</tr>
<tr>
<td>Fetal Sample</td>
<td>Please indicate Gestational age. 20 mL of amniotic fluid or 20 mg of chorionic villi in sterile transport container. Ship overnight at room temperature. In hot weather a cool pack may be enclosed. Do not freeze. Please call 317-944-7597 when sending fetal samples. Laboratory Hours Mon-Fri 8:30 am-5:00 pm. Both maternal and fetal specimens are sent to Cytogenetic Laboratory at IB 265, 975 W. Walnut Street, Indianapolis, IN 46202, 317-274-2243.</td>
</tr>
<tr>
<td>Buccal Brush</td>
<td>Buccal brush collection kit is available. Please call 317-944-7597 to request. Follow the included instructions to collect buccal brushes. Return buccal brush specimens at ambient temperature.</td>
</tr>
</tbody>
</table>

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**FINANCIAL INSURANCE WAIVER FORM:**

**IMPORTANT:** Patient and health care providers desiring private insurance billing MUST complete and submit the signed Patient Financial Insurance Waiver Form prior to or at the time of sample submission. *Failure to do so may delay testing/results.*

**Financial Responsibility for My Account**

I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity or otherwise. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State and Federal law.

A duplicate or faxed copy of this authorization is considered the same as the original document.

______________________________  ________________________________  __________________________
Signature of Patient/Responsible Party  Printed Name of Patient/Responsible Party  Date

(Patient/Responsible Party Must be 18 Yrs of Age)

**Health Care Providers Please Provide the Following:**

1. Provide the patient’s diagnosis or ICD-10 code(s) in the “Clinical Info” section on the front page of this form.
2. Indicate billing as requested in the billing section on the front page of this requisition form.
3. If “Patient (Insurance/Medicare/Medicaid)” box has been indicated on front of this form, include complete patient demographic sheet (if patient is under 18 years of age/child include parent/guardian demographics)
4. Include an enlarged copy of patient’s insurance card(s) (both front and back).
5. Ensure the above portion of this Financial Insurance Waiver has been signed by the responsible party.

**Patient Authorization for Insurance Benefit Verification**

Any necessary prior-authorization should be completed by the health care provider. If the prior-authorization has been completed, please provide the prior authorization number: