

PATIENT INFORMATION

PATIENT D.O.B. _____

PATIENT LAST NAME _____ FIRST NAME _____ MI _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX: M F _____ DUKE HISTORY # _____

PATIENT TELEPHONE #: _____

REQUESTING INSTITUTION PATIENT ID CODE: _____

*****The DUHS Molecular Diagnostics Laboratory does not bill patients or their insurance companies. The submitting physician/institution is charged for all non-Duke patient testing.**

INDICATION

Indications for Study: (REQUIRED)

REQUIRED: Ethnicity of Patient (circle): Other: _____

African-American Asian-American European-Caucasian
 Hispanic-Caucasian Ashkenazi-Jewish

SPECIMEN COLLECTION

COLLECTION DATE ____/____/____ TIME: ____

SPECIMEN TYPE* :

Bone Marrow Peripheral blood
 Buccal Swab Fresh Tissue
 Paraffin Block*** Other: _____

***For archival paraffin-embedded tissue, please provide the Surgical Pathology case number as well as the block number to be tested:

S ____ - ____ **block** _____

- *Blood and bone marrow: purple top EDTA tubes; 3-6mls for most tests.*
- *Fresh tissue: freeze if not arriving in the lab within 4 hours of collection*
- *Samples should arrive in the lab within 24 hours of collection and may be transported at room temperature.*
- *Buccal swab collection kits are available from the lab (919-684-2698).*
- *For studies on paraffin tissue, please do not send slides as the microtome must be specially prepared. The block will be returned once testing is complete.*

MOLECULAR MICROBIOLOGY

Human Papillomavirus (HPV) DNA – HR
 [cervical samples in Cytoc PreservCyt solution only]
 Reflex to HPV 16/18 Genotyping
 Epstein-Barr Virus (EBV Quantitative PCR) [blood and bone marrow only]
 CMV Genotyping [EDTA plasma]
 HCV Genotyping [serum or EDTA plasma]

CLIENT INFORMATION

PHYSICIAN NAME AND ADDRESS: (Results will be sent to this address)

REQUESTING PHYSICIAN (PLEASE PRINT) _____

REQUESTING PHYSICIAN SIGNATURE **(REQUIRED)** _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE # _____ FAX # _____

EMAIL _____

BILLING CONTACT NAME AND ADDRESS: (Required)

INSTITUTION / CONTACT PERSON _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE # _____ FAX # _____

MOLECULAR ONCOLOGY

B Cell Clonality/ Gene Rearrangement (B Cell IgH/IgKappa Chain PCR)
 T Cell Clonality/ Gene Rearrangement (T Cell Gamma/Beta Chain PCR)
 IGH Somatic Mutation Analysis
 BCR/ABL1 t(9;22) Quantitative PCR
 ABL1 Kinase Domain Sequencing
 JAK2 V617F Mutation Analysis
 NPM1 Targeted Mutation Analysis
 IDH1 Targeted Mutation Analysis with reflex to IDH2
 KRAS Targeted Mutation Analysis
 Reflex to BRAF V600E Mutation Analysis if KRAS Negative
 BRAF V600E Mutation Analysis with reflex to V600K for melanoma cases
 Microsatellite Instability (MSI) by PCR ***
 c-KIT Targeted Mutation Analysis for GIST or melanoma
 TP53 Gene Sequencing
 EGFR Targeted Mutation Analysis
 Bone Marrow Engraftment Analysis (BME) via STR Profiling
 BME - Pre-Transplant Recipient Sample
 BME - Donor Sample

 Donor: _____
 BME –Post Transplant
 Whole CD3+ CD15+
 Sample Identity (Sample Identity Analysis via Short Tandem Repeat Profiling) – call laboratory

*****Please note that informed consent is required for all genetic testing (to be obtained by the ordering physician)**

MOLECULAR GENETICS

<input type="checkbox"/> AMD (Age-Related Macular Degeneration) CFH and ARMS2 Genotyping <input type="checkbox"/> Apolipoprotein E (ApoE) Genotyping <input type="checkbox"/> Cystic Fibrosis (CFTR Targeted Mutation Analysis) <input type="checkbox"/> Include 5/7/9T IVS-8 Analysis <input type="checkbox"/> Fragile X (FMR1 Triplet Repeat Analysis) <input type="checkbox"/> Hemochromatosis (HFE Targeted Mutation Analysis) <input type="checkbox"/> Prader-Willi/Angelman Syndrome Methylation PCR <input type="checkbox"/> Interleukin 28B (IL28B) Genotyping <input type="checkbox"/> UDP-Glucuronosyltransferase (UGT1A1) Genotyping	<input type="checkbox"/> DNA Extraction and Storage <input type="checkbox"/> TMPRSS6 Sequencing (IRIDA) <input type="checkbox"/> TP53 Sequencing (Li-Fraumeni) <input type="checkbox"/> TRPC6 Sequencing (FSGS) <input type="checkbox"/> TGFB1 Sequencing (Corneal dystrophy) <input type="checkbox"/> MYH9 Sequencing <input type="checkbox"/> MOCS1 Sequencing (Molybdenum cofactor deficiency) <input type="checkbox"/> MOCS2 Sequencing (Molybdenum cofactor deficiency) <input type="checkbox"/> SUOX Sequencing (Sulfite oxidase deficiency)	<input type="checkbox"/> G6PC Sequencing (GSD Ia) <input type="checkbox"/> SLC37A4 Sequencing (GSD Ib) <input type="checkbox"/> GAA Sequencing (Pompe/GSD II) <input type="checkbox"/> AGL Sequencing (GSD III) <input type="checkbox"/> GBE1 Sequencing (GSD IV) <input type="checkbox"/> PHKA2 Sequencing (GSD IXa/XLG) <input type="checkbox"/> PHKG2 Sequencing (GSD IXc) <input type="checkbox"/> GLA Sequencing (Fabry)
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