UPMC LIFE CHANGING MEDICINE

REQUISITION FORM
Magee-Womens Hospital of UPMC
Pittsburgh Clinical Genomics Laboratory
300 Halket Street Room 4680
Pittsburgh, PA 15213
Phone (412) 641-2949 | Fax (412) 641-2893

PATIENT INFORMATION ***(Please Print):***	**REFERRING PHYSICIAN** ***(Please Print):***
Last Name: **First:** M.I.:	**Name:**
Address: City, State, Zip:	**Address:** **City, State, Zip:**
Home Phone #:	**Fax:**
Birthdate: ____/____/____ **Sex:** ____ Female ____ Male **Race/Ethnicity (check all that apply):** ☐ White/Caucasian ☐ Black/African American ☐ Hispanic ☐ Asian/Asian American ☐ Ashkenazi Jewish ☐ Other (specify):	Additional Report To:
Medical Record #: Account#:	Fax:
Send Bill To: ☐ Patient ☐ Insurance (please attach insurance information) ☐ Institution (list): ____________________________________	Comments/Special Instructions:

SPECIMEN INFORMATION:	**PREGNANCY INFORMATION:**
Date/Time of Collection: ____/____/____ ___:___ **Type of Specimen:** ☐ Peripheral Blood ☐ Extracted DNA Source of Extracted DNA: ☐ CVS ☐ Amniotic Fluid ☐ Peripheral Blood	**Is testing associated with a current pregnancy?** ☐ No ☐ Yes, Gestational Age at time of test order ____ wks ___ days or LMP ___/___/___ Multiple gestation? ☐ Yes ☐ No ART/IVF? ☐ Yes ☐ No Gamete donor? ☐ Yes ☐ No If yes, ☐ Egg ☐ Sperm Surrogate pregnancy? ☐ Yes ☐ No

INDICATION FOR STUDY:

☐ Diagnostic/Suspected diagnosis
List clinical findings: ____
____
____

☐ Carrier screening
☐ Positive family history
Relationship to patient: ____
Gene variants known in family: ____
☐ Abnormal fetal ultrasound
List findings: ____
____
☐ Other (list): ____

TEST(S) REQUESTED:

☐ **Cystic fibrosis (*CFTR*) 144 variant panel**
☐ **Cystic fibrosis (CFTR) sequencing**
☐ **Cystic fibrosis (CFTR) targeted variant analysis**
Variants to be analyzed: ____
☐ **Maternal cell contamination (MCC)**
☐ **CYP2C19**

Signature of Requesting Physician (REQUIRED):

Please complete all fields on this requisition. Failure to complete the test requisition will delay patient results.