

UCDHSC DNA Diagnostic Laboratory

Phone: (303) 724-3801 Send Request Form and Consent Form with specimen.

Fax: (303) 724-3802 Unlabeled specimens will not be processed.

Shipping address for specimens:

RC1-North, Rm P18-4404K, 12800 E. 19th Ave, Aurora, CO 80045

Mailing address for correspondence:

Mail Stop 8313, PO Box 6511, Aurora, CO 80045

DNA Analysis Request Form: NKH

(Before printing form, click File – Page Setup – Margins 0.5 all round.)

Patient's Last Name: _____

First: _____ MI: _____

Sex: M F DOB: ___/___/___

Hospital/ID Number: _____

Referring Physician/Geneticist/Genetic Counselor

Billing information (must be complete to process sample)

Name(s): _____

We bill the institution. We do not bill insurance.

MD Phone: (____) - _____ Fax: (____) - _____

We give a 5% discount for prepayments by check from patients.

GC Phone: (____) - _____ Fax: (____) - _____

Full mailing address for bill: _____

Full mailing address for report: _____

Signature: _____

Phone: (____) - _____ Fax: (____) - _____

Previous DNA studies

Please send clinical information on the affected child.

YES___ NO___ (if YES, specify)

Analysis performed: _____

Individual(s) studied: _____

Approximate date of study: _____

Laboratory: _____

Additional family members to be studied / Relationship

1. _____

2. _____

Indications for test (please include ICD-9s): _____

Ethnic background (Important for accurate interpretation)

African American S European Caucasian NW European Caucasian Mixed European Caucasian

Hispanic Native American Indian Asian New Zealand (Maori)

Ashkenazi Jewish Other Jewish Other: _____

Genetic disorder to be studied

NKH comprehensive NKH *AMT* gene (T-protein) NKH *GLDC* gene (P-protein) NKH *GCSH* gene (H-protein)

Other _____ NKH known mutations (specify) _____

Please indicate pedigree

Analysis requested

Diagnostic Carrier identification Prenatal diagnosis Other _____

Blood specimen information (EDTA purple top tubes, room temp): We strongly advise sending samples from both parents with the sample from the affected child. Parents' carrier testing is included at no additional charge.

Sample sent for Mom? Y N Dad? Y N

Child: Time/date of sample collection _____ Approx. volume ___ml Number of tubes _____

Mom: Time/date of sample collection _____ Approx. volume ___ml Number of tubes _____

Dad: Time/date of sample collection _____ Approx. volume ___ml Number of tubes _____

Prenatal information: Maternal cell contamination studies (MCC) are performed together with prenatal testing.

Send maternal blood sample unless stored maternal DNA is available from previous testing. MCC sent? Y N

Amniotic fluid: ___ml Chorionic villi sampling: ___mg Cultured cells: ___ T25s Twin gestation? Y N

LMP ___/___/___ Date of U/S ___/___/___ Gestation by U/S _____ Sex of fetus (if known) M F