Laboratory of Personalized Genomic Medicine
Department of Pathology and Cell Biology

COLUMBIA UNIVERSITY MEDICAL CENTER

630 West 168th Street
P&S 17th Floor, Room 401
New York, NY 10032

Tel: 212-305-9706
Fax: 212-342-0420

Molecular Genetic Pathology Testing Requisition Form

Must be filled out completely. Informed consent MUST be signed by the Patient, Parent/Legal Guardian or Legal Next of Kin.

Internal Use Only - Accession #:_____

PATIENT INFORMATION:

LAST NAME: FIRST NAME: M.I.:

DATE OF BIRTH: MRN: GENDER: ☐ MALE ☐ FEMALE

ADDRESS:

CITY, STATE & ZIP:

HOME PHONE: WORK PHONE:

INSURANCE INFORMATION:

NAME OF POLICY HOLDER: DATE OF BIRTH:

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME & ADDRESS OF INSURANCE COMPANY:

POLICY NUMBER: GROUP NUMBER:

SECONDARY INSURANCE CARRIER: NAME OF POLICY HOLDER:

POLICY NUMBER: GROUP NUMBER:

MEDICARE PATIENTS ONLY: Check here to confirm that an Advance Beneficiary Notice (**ABN**) was signed by the Patient: ☐

CREDIT CARD: I have provided my credit card information to the Pathology Billing Office (call 212-305-7399 to provide card information). ☐

PREAUTHORIZATION: If health insurance preauthorization is required, check here if preauthorization is pending: ☐

ORDERING PHYSICIAN INFORMATION:

LAST NAME: FIRST NAME: M.I.:

INSTITUTION: NPI #:

ADDRESS:

CITY, STATE & ZIP:

TELEPHONE NUMBER: FAX NUMBER:

EMAIL ADDRESS:

SIGNATURE: DATE:

GENETIC COUNSELOR NAME: EMAIL ADDRESS:

INSTITUTIONAL BILLING: Do you have a PGM Billing Account?

☐ Yes P.O. #_____

☐ No (Email PGMbilling@cumc.columbia.edu to establish an account)

NOTE TO HEALTH CARE PRACTITIONER: It is New York State Law and Columbia University Policy that an informed consent is obtained prior to performing genetic predisposition testing and maintained in the patient's medical record. Please use the appropriate disease/gene information/informed consent sheet, ensure that the patient/legal guardian understands its contents, and obtain the person's signature. If the patient consents to having the sample retained in the lab for greater than 60 days, please include a copy of the consent form with this requisition. **I have obtained a signed informed consent to perform genetic testing in accordance with New York State Civil Rights Law, 79-L, and the informed consent is retained in the patient's medical record.:** ☐

SAMPLE INFORMATION:

SAMPLE TYPE: ☐ AMNIOTIC FLUID ☐ BLOOD (EDTA OR HEPARIN) ☐ BUCCAL SWAB ☐ CHORIONIC VILLI ☐ DNA ☐ PRODUCTS OF CONCEPTION

PROBAND SAMPLE:

P1: PATIENT NAME: _____ DOB:_____ MRN: _____ DATE COLLECTED: / /

PARENT / SIBLING SAMPLES:

C1: MOTHER NAME: _____ DOB:_____ C3: SIBLING NAME: _____ DOB:_____

C2: FATHER NAME: _____ DOB:_____ C4: SIBLING2/OTHER NAME: _____ DOB:_____

TEST ORDERED (FILL IN COMPLETELY):

MOLECULAR TESTING

☐ **Cystic Fibrosis Screening**

☐ **FMR1 – Fragile X**

☐ **LGI1 Test**

☐ **Prader-Willi /Angelman Syndrome DNA Analysis**

☐ **Spinal Muscular Atrophy (SMA)**

☐ **C9orf GGGGCC Repeat Expansion**

☐ **Sanger Sequencing of Targeted Gene**

GENE: _____

VARIANT OF INTEREST: _____

☐ **Thrombophilia Risk Panel 1**
- Factor V Leiden
- Prothrombin 20210G>A Mutations

☐ **Thrombophilia Risk Panel 2**
- Factor V Leiden
- MTHFR Mutations,
- Prothrombin 20210G>A Mutations

☐ **Warfarin Sensitivity Test**
- CYP2C9*2, CYP2C9*3
- VKORC1-1639 A/G Variants

CHROMOSOMAL MICROARRAY

☐ **SNP Oligonucleotide Microarray Analysis (SOMA) Cytoscan HD*** *Select Test Type*

☐ TARGETED ☐ WHOLE GENOME

*Method subject to change at discretion of Pathologist

NEXT-GENERATION SEQUENCING

☐ **Whole Exome Sequencing***

☐ **mtDNA Whole Genome Sequencing***

☐ **Columbia Combined Genetic Panel (CCGP)*** – *Select Panel Below*

☐ AUTISM PANEL ☐ HEMATOLOGICAL PANEL
☐ CARDIOVASCULAR PANEL ☐ MITOCHONDRIAL PANEL
☐ CONNECTIVE & METABOLIC PANEL ☐ NEUROMUSCULAR PANEL
☐ DERMATOLOGICAL PANEL ☐ NOONAN PANEL
☐ EYE DISEASE PANEL ☐ RENAL PANEL
☐ HEARING LOSS PANEL ☐ SEIZURE/EPILEPSY PANEL

☐ **Columbia Combined Genetic Panel <20*** – Custom 20 Gene Panel

☐ **Columbia Combined Genetic Panel 20-40*** – Custom 30 Gene Panel

☐ **Columbia Combined Genetic Panel > 40*** – Custom 40+ Gene Panel

* Signed Informed Consent Required

ICD-10 CODE(S)

CUSTOM GENE PANELS ONLY – GENES REQUESTED FOR EVALUATION *List Below*

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Molecular Genetic Pathology Patient Medical Questionnaire

To support the laboratory analysis, please provide a detailed clinical picture of the patient's clinical syndrome, the clinical differential diagnosis, and a pedigree. All of these will help in the interpretation of the pathogenicity of the variants that will be found.

PATIENT INFORMATION

LAST NAME: | FIRST NAME: | DATE OF BIRTH: | TODAY'S DATE:

GENDER: ☐ MALE ☐ FEMALE

ETHNIC BACKGROUND: ☐ AFRICAN AMERICAN ☐ ASHKENAZI JEWISH ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ NATIVE AMERICAN ☐ OTHER JEWISH ☐ OTHER _____

REASON FOR TESTING / CLINICAL INFORMATION

CLINICAL DIAGNOSIS: | AGE OF ONSET:

POSITIVE FAMILY HISTORY: ☐ YES ☐ NO ☐ N/A IF YES, EXPLAIN: | DECEASED: ☐ YES ☐ NO | AUTOPSY: ☐ YES ☐ NO

OTHER SIGNIFICANT OBSERVATIONS:

GENERAL SYMPTOMS / SIGNS

☐ BEHAVIORAL/ PSYCHIATRIC
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Anxiety
- ☐ Autism
- ☐ Behavioral/Psychiatric Abnormality
- ☐ Dementia
- ☐ Pervasive Developmental Delay

☐ CARDIAC
- ☐ Aortic Atresia
- ☐ ASD
- ☐ AV Canal Defect
- ☐ Atrial Septal Defect
- ☐ Coarctation of the Aorta
- ☐ Congestive Heart Failure
- ☐ Dextrocardia and Situs Inversus
- ☐ Double Outlet Right Ventricle
- ☐ Ebstein's Anomaly
- ☐ Echogenic Intracardiac Focus
- ☐ Hypoplastic Left Heart
- ☐ Pulmonary Valve Atresia
- ☐ Tetralogy of Fallot
- ☐ Transposition of the Great Vessels
- ☐ Truncus Arteriosus
- ☐ Ventricular Septal Defect

☐ COGNITIVE/DEVELOPMENTAL
- ☐ Learning Disability
- ☐ Developmental Delay
  - ☐ Gross Motor Delay
  - ☐ Fine Motor Delay
  - ☐ Speech Delay
- ☐ Intellectual Disability/MR

☐ CRANIOFACIAL
- ☐ Cleft Lip +/- Cleft Palate
- ☐ Dysmorphic Facial Features
- ☐ Ear Malformation
- ☐ Hyper/Hypotelorism
- ☐ Macrocephaly
- ☐ Microcephaly

☐ CUTANEOUS
- ☐ Acne
- ☐ Alopecia
- ☐ Axillary/Inguinal Freckling
- ☐ Blisters
- ☐ Café-Au-Lait Spots
- ☐ Congenital Nevus
- ☐ Ectodermal Dysplasia
- ☐ Ichthyosis
- ☐ Loose Skin

CUTANEOUS (CONTINUED):
- ☐ Papules
- ☐ Psoriasis
- ☐ Striae
- ☐ Urticaria

☐ ENDOCRINE/ EXOCRINE:
- ☐ Adrenal
- ☐ Bone
- ☐ Diabetes Mellitus
- ☐ Hypothalamus
- ☐ Pancreas
- ☐ Parathyroid
- ☐ Pituitary
- ☐ Reproductive
- ☐ Thyroid

☐ GASTROINTESTINAL
- ☐ Absent Stomach
- ☐ Echogenic Focus
- ☐ Gastrointestinal Pseudo Obstruction
- ☐ Gastroschisis
- ☐ Meconium Ileus/ Anal Atresia
- ☐ Omphalocele
- ☐ Tracheoesophageal Fistula
- ☐ Pyloric Stenosis

☐ GENITOURINARY
- ☐ Ambiguous Genitalia
- ☐ Cryptorchidism
- ☐ Hydronephrosis
- ☐ Hypoparathyroidism
- ☐ Hypospadias
- ☐ Hypothyroidism
- ☐ Kidney Malformation
- ☐ Megacystis (incl. posterior valves)
- ☐ Myoglobinuria
- ☐ Polycystic Kidneys
- ☐ Renal Agenesis
- ☐ Urethra/Ureter Obstruction

☐ GROWTH
- ☐ Failure to Thrive
- ☐ Overgrowth
- ☐ Short Stature

☐ HEARING/VISION
- ☐ Abnormality of Vision
- ☐ Abnormality of Eye Movement
- ☐ Hearing Loss
- ☐ Migraine Headache
- ☐ Optic Atrophy
- ☐ Ptosis
- ☐ Retinopathy

☐ HEMATOLOGY
- ☐ Anemia
- ☐ Clotting Disorder
- ☐ Hemophilia
- ☐ Neutropenia
- ☐ Thrombocytopenia

☐ IMMUNE SYSTEM
- ☐ Autoimmune Disorders
- ☐ Immunodeficiency

☐ METABOLIC/ LABORATORY ABNORMALITIES
- ☐ Biliary Tract
- ☐ Blood Gases
- ☐ Electrolytes
- ☐ Gastrointestinal
- ☐ Glycoproteins
- ☐ Kidney
- ☐ Lipids
- ☐ Liver
- ☐ Mitochondrial
- ☐ Pancreas

☐ MUSCULOSKELETAL
- ☐ Acromelia
- ☐ Clenched Hands
- ☐ Club Foot (bilateral)
- ☐ Contractures (arthrogryposis)
- ☐ Cramps After Exercise
- ☐ Diaphragmatic Hernia
- ☐ Exercise Intolerance
- ☐ Joint Laxity
- ☐ Limb Anomaly
- ☐ Mesomelia
- ☐ Micromelia
- ☐ Myoclonus
- ☐ Ophthalmoplegia
- ☐ Scoliosis
- ☐ Polydactyly
- ☐ Proximal Limb Weakness
- ☐ Skeletal Dysplasia
- ☐ Syndactyly
- ☐ Vertebral Anomaly

☐ NEOPLASIA
- ☐ Cancer Syndromes
- ☐ Malignancies
- ☐ Breast
- ☐ CNS
- ☐ Endocrine
- ☐ GI
- ☐ GU
- ☐ Hamartoma

NEOPLASIA (CONTINUED):
- ☐ Head and Neck
- ☐ Hematopoietic/ Lymphatic
- ☐ Intrathoracic
- ☐ Neurofibroma
- ☐ Optic Gliomas
- ☐ Skin, Soft Tissue, Bone and Joints

☐ NEUROLOGICAL
- ☐ Abnormal Gyri (Lissencephaly)
- ☐ Agenesis of the Corpus Callosum
- ☐ Asthenia
- ☐ Cerebellar Hypoplasia
- ☐ Cerebellar Signs
- ☐ Cerebral Blindness
- ☐ Cerebral Palsy
- ☐ Dandy Walker (posterior fossa abnormality)
- ☐ Encephalopathy
- ☐ Headache
- ☐ Holoproscencephaly
- ☐ Hypertonia
- ☐ Hypotonia
- ☐ Macrocephaly
- ☐ Microcephaly – List HC if known:
- ☐ Neuropathy
- ☐ Neural Tube Defect
- ☐ Seizures
- ☐ Stroke
- ☐ Structural Brain Anomaly
- ☐ Ventriculomegaly/Hydrocephaly

☐ PRENATAL/PERINATAL HISTORY
- ☐ 2 Vessel Cord
- ☐ Decreased Fetal Movement
- ☐ Echogenic Focus
- ☐ Floppy Baby
- ☐ Increased Nuchal Translucency
- ☐ IUGR
- ☐ Non-Immune Hydrops Fetalis
- ☐ Oligohydraminos
- ☐ Perinatal Insult
- ☐ Polyhydramnios
- ☐ Prematurity

☐ PULMONARY
- ☐ CCAM/Small Thoracic Cavity
- ☐ Diaphragmatic Hernia
- ☐ Eventration of Diaphragm
- ☐ Pleural Effusion
- ☐ Pulmonary Sequestration
- ☐ Respiratory Insufficiency

OTHER SYMPTOMS *List and describe*

PREVIOUS TESTING & STUDIES *List and describe*

COLLECTION REQUIREMENTS *Samples not to exceed 3 tubes, regardless of testing*

CYSTIC FIBROSIS SCREENING	(1) 2mL Lavender-top EDTA Tube
LGI1 TEST	(1) 2mL Lavender-top EDTA Tube
PRADER-WILLI/ANGELMAN DNA ANALYSIS	(2) 2mL Lavender-top EDTA Tube
SANGER SEQUENCING FOR TARGETED GENE	(1) 2mL Lavender-top EDTA Tube
THROMBOPHILIA RISK PANEL	(1) 2mL Lavender-top EDTA Tube
WARFARIN SENSITIVITY TEST	(1) 2mL Lavender-top EDTA Tube

SOMA CYTOSCAN HD, TARGETED & WHOLE GENOME

PERIPHERAL BLOOD	(2) 2-3mL LAVENDER-TOP EDTA/SODIUM HEPARIN TUBE
AMNIOTIC FLUID	AT LEAST 10ML
CHORIONIC VILLI	AT LEAST 3ML
POC	AT LEAST 3MG
DNA	AT LEAST 250NG

WHOLE EXOME SEQUENCING

WHOLE BLOOD IN EDTA	(1) 2mL LAVENDER-TOP EDTA TUBE
	• Children - at least 5cc; Adult - 10 cc
GENOMIC DNA	20ug of purified DNA

CCGP & CUSTOM PANELS

WHOLE BLOOD IN EDTA	(1) 2mL LAVENDER-TOP EDTA TUBE