

COLLECTION INFORMATION: <input type="checkbox"/> AM <input type="checkbox"/> PM		
DATE _____ TIME _____ INITIALS _____		
ACCOUNT INFORMATION		
NAME _____		
ADDRESS _____		
CITY _____	STATE _____	ZIP _____
PHONE _____		
FAX _____		
ORDERING PHYSICIAN _____		
SECOND REPORT TO _____		
ACCOUNT _____	PATIENT ACCT. _____	RESEARCH ACCT. _____

MOLECULAR DIAGNOSTIC LABORATORY
 Barnes-Jewish Hospital, Institute of Health
 425 South Euclid Avenue
 Room 5970, Mailstop #90-28-344
 St. Louis, MO 63110

Barnes-Jewish Hospital
 BJC HealthCare

(314) 454-8685, 314-121-3914; FAX (314) 454-7616
 URL: <https://pathology.wustl.edu/clinical-services/molecular-diagnostics-laboratory/>

PATIENT INFORMATION			
PATIENT LAST NAME OR ID# _____	FIRST _____	DOB _____	LEGAL SEX _____
DIAGNOSIS CODE _____			
PATIENT'S ADDRESS _____		CITY _____	STATE _____ ZIP _____ PHONE _____
BILLING INFORMATION } BILL TO: <input type="checkbox"/> ACCOUNT <input type="checkbox"/> PATIENT <input type="checkbox"/> INSURANCE <input type="checkbox"/> RESEARCH ACCT.			
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> CARE PARTNERS	<input type="checkbox"/> PARTNERS HMO
ID # _____	ALPHA Code _____	<input type="checkbox"/> GHP	<input type="checkbox"/> OTHER _____
INSURANCE CO. _____		I.D. # _____	
ADDRESS _____		GRP. # _____	
INSURED NAME (IF NOT PATIENT) _____		PLAN NAME _____	

Test Requested:

Check box sample type	
Inherited Disorders	
Fragile X Carrier Screen	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	DNA*
Factor V Leiden (FVL) Mutation	
<input type="checkbox"/>	Blood (EDTA)
Prothrombin (F2) Mutation	
<input type="checkbox"/>	Blood (EDTA)
Hemochromatosis (HFE) Genotyping	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	DNA*
Pharmacogenetics	
UGT1A1 Genotyping	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	DNA*
Oncology	
BCR::ABL1 p210 IS, Quant	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	Bone marrow (EDTA)
<input type="checkbox"/>	RNA*
BCR::ABL1 p190, Quant	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	Bone marrow (EDTA)
<input type="checkbox"/>	RNA*

Check box sample type	
Oncology, cont.	
JAK2 V617F, Quant	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	Bone marrow (EDTA)
<input type="checkbox"/>	DNA*
IGH Hypermutation (IGHV), NGS w/Interp	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	Bone marrow (EDTA)
<input type="checkbox"/>	FFPE
<input type="checkbox"/>	Fresh Tissue
<input type="checkbox"/>	DNA*
IGH Rearrangement (B Cell Clonality), NGS w/Interp	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	Bone marrow (EDTA)
<input type="checkbox"/>	FFPE
<input type="checkbox"/>	Fresh Tissue
<input type="checkbox"/>	DNA*
TCRG Rearrangement (T Cell Clonality), NGS w/Interp	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	Bone marrow (EDTA)
<input type="checkbox"/>	FFPE
<input type="checkbox"/>	Fresh Tissue
<input type="checkbox"/>	DNA*

Check box sample type	
Oncology, cont.	
STR Comprehensive (Patient Pre-BMT)	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	Bone marrow (EDTA)
<input type="checkbox"/>	Buccal swabs
<input type="checkbox"/>	DNA*
STR Donor (Donor Pre-BMT)	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	Bone marrow (EDTA)
<input type="checkbox"/>	Buccal swabs
<input type="checkbox"/>	DNA*
STR Identity Testing	
<input type="checkbox"/>	Blood (EDTA)
<input type="checkbox"/>	Bone marrow (EDTA)
<input type="checkbox"/>	DNA*
STR Enrichment Identity Testing Blood (EDTA)	
Select cell lines (3 mL whole blood per cell line)	
<input type="checkbox"/>	CD3 (T cell)
<input type="checkbox"/>	CD15 (Myeloid cell)
<input type="checkbox"/>	CD19 (B cell)
<input type="checkbox"/>	CD56 (NK cell)
Other test(s) requested	

*DNA/RNA must be extracted in a CLIA/CAP certified laboratory. Circle one: CLIA CAP Cert # _____

Clinical Information:
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