Washington University Physicians®

SEQUENCING: Congenital Neutropenia

Sample shipping address:

Washington University Department of Pathology & Immunology
Clinical Support Office
425 S. Euclid Ave. | MSC 8024-14-4711 | St. Louis MO 63110
Tel: (314) 747-7337| Fax: (314) 747-7336

Sample drop-off locations:

Children's Hospital
One Children's Place
Central Receiving 2N-25
St. Louis, MO 63110
Tel: (314) 454-4161

North Campus Lab
Institute of Health (IOH) Core Lab
425 S. Euclid Ave. | Room 4701
St. Louis, MO 63110
Tel: (314) 362-1470

This requisition has two pages, please complete both pages to ensure testing.

PATIENT IDENTIFICATION

Patient Status: ☐ Inpatient ☐ Outpatient ☐ Office Visit

Name Last: | First: | MI:

DOB (mm/dd/yyyy): | Sex: ☐ Male: ☐ Female:

Medical Record # (if applicable):

Address:

City: | State: | Zip:

Ethnicity (select all that apply)

☐ African American ☐ Asian ☐ Caucasian/NW European
☐ E Indian ☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic
☐ Mediterranean ☐ Native Hawaiian/Pacific Islander ☐ Other

PHYSICIAN ORDERING TEST (NPI required)

Name:

Institution:

NPI: | Email:

Address:

City: | State: | Zip:

Phone: | Fax:

Alternative Contact Information:

Phone: | Email:

Notes:

SPECIMEN TYPE

Date Collected (mm/dd/yyyy): | Time:

Collected By:

Sample Type (Select one)

☐ Peripheral Blood ☐ Other

Directions
1. Draw 3-5 ml of peripheral blood in lavender top EDTA tube
2. Label tube with patient first/last name, DOB, and collection date/time
3. Place tube in a biohazard bag and form into document sleeve of the biohazard bag ensuring no patient information is visible
4. Ship specimen overnight in appropriate packaging at room temperature or with cold pack (Monday-Thursday only)

REASON FOR TESTING (Required-failure to include diagnosis may delay testing)

Diagnosis:

ICD10 Code(s):

PATIENT REGISTRY

Is the patient enrolled in The Severe Chronic Neutropenia International Registry (SCNIR)? ☐ Yes ☐ No

If no, would you like to be contacted by the SCNIR for more information? ☐ Yes ☐ No

TESTING REQUESTED

All tests include next generation sequencing of all coding exons of listed genes to detect SNV's and small insertions and deletions. For starred tests (*) when negative results or isolated heterozygous mutations are detected, additional testing by alternate methodology will be performed to determine the presence of rare variant types not detected by this assay.

☐ ***Severe Congenital Neutropenia Gene Set with interpretation** *(AK2, AP3B1, ASXL1, CD40LG, CLPB, CSF3R, CXCR2, CXCR4, DNAJC21, DNM2, DOCK2, EFL1, EIF2AK3, ELANE, G6PC3, GATA1, GATA2, GFI1, GINS1, HAX1, IRAK4, JAGN1, KAT6A, KRAS, LAMTOR2, LYST, MYD88, NRAS, PGM3, PSTPIP1, RAB27A, RAC2, RUNX1, SBDS, SLC37A4, SMARCD2, SRP54, STK4, TAZ, TCIRG1, TCN2, TP53, USB1, VPS13B, VPS45, WAS, WDR1 and WIPF1)*

Targeted testing for known familial variant	Gene:	Variant:
Please include copy of proband report		Relationship to patient above:

ADDITIONAL NOTES:

Healthcare Professional Signature to Authorize Testing, Statement of Medical Necessity and Transmission of Results Verification

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

The undersigned Client authorizes the Washington University School of Medicine to send Protected Healthcare Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number above. Client acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.

Signature: | Date:

Below, office use only:

Date/Time Received: | Accession Number: | Technician Initial:

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):

INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at (314) 362-5641 or via email at path-billing@email.wustl.edu for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):
CPT Codes and Units Authorized:	

ATTACH COPY OF INSURANCE CARD (if not available, complete the following)

Policy Holder's Name: Last First MI	Insurance Co. Name:	
Policy Holder's Date of Birth (mm/dd/yyyy):	Insurance Co. Phone:	
Relationship to patient:	Plan Name:	
	ID#:	Group#:

SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our Patient Accounts Manager office at (314) 362-5641 or via email at path-billing@email.wustl.edu.

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

Institution Name:		
Contact Name:		
Email:		
Billing Address:		
City:	State:	Zip:
Phone:	Fax:	