



**SEND SPECIMEN OVERNIGHT TO:**  
University Children's Genetics Laboratory,  
A Division of ProGene, Inc.  
116 E. Broadway  
Glendale, CA 91205

**Molecular Genetics Section**  
Toni R. Prezant, PhD: Dir., Molecular Genetics  
Linda S. Cowan, MD: Medical Director  
Tel (818) 548-0999 Fax (818) 548-1555  
<http://www.progene.us>

### CLIENT INFORMATION

Facility Name, Mailing Address, Phone, Fax: \_\_\_\_\_  
Ordering Dr.: \_\_\_\_\_  
Dr.'s Phone: \_\_\_\_\_  
Dr.'s Fax: \_\_\_\_\_  
State & Dr.'s License #: \_\_\_\_\_  
Referring Facility P.O. #: \_\_\_\_\_

### PATIENT INFORMATION

Last Name: \_\_\_\_\_ Patient I.D. or MR #: \_\_\_\_\_  
First Name: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female If pregnant, Gestation Age: \_\_\_\_\_

### SPECIMEN INFORMATION

Collection Date: \_\_\_\_\_ Collection Time: \_\_\_\_\_ Specimen ID #: \_\_\_\_\_  
Specimen Type:  Blood  Amniocytes, cultured  Skin  
 Muscle  Chorionic Villi, cultured  Other:  
Was informed consent obtained? \_\_\_\_\_ Yes \_\_\_\_\_ No

### REQUESTED TESTS

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> <b>Ashkenazi Jewish Panel (all 5)</b><br><input type="checkbox"/> Canavan Disease<br><input type="checkbox"/> Cystic Fibrosis<br><input type="checkbox"/> Familial Dysautonomia<br><input type="checkbox"/> Gaucher Disease<br><input type="checkbox"/> Tay-Sachs Disease | <input type="checkbox"/> Fragile X<br><input type="checkbox"/> GSD Type 1A<br><input type="checkbox"/> HFI<br><input type="checkbox"/> LCHAD<br><input type="checkbox"/> MCAD<br><input type="checkbox"/> Myotonic Dystrophy<br><input type="checkbox"/> Prader-Willi/Angelman<br><input type="checkbox"/> Spinal Muscular Atrophy<br><input type="checkbox"/> Twin Zygosity (identity testing)<br><input type="checkbox"/> UPD study for chromosome _____<br><input type="checkbox"/> Other: | <b>PKU:</b><br><input type="checkbox"/> Direct mutation<br><input type="checkbox"/> Linkage<br><input type="checkbox"/> Point mutation panel<br><i>(Batched run: 3 patients minimum)</i><br><input type="checkbox"/> Sequencing<br><i>Optional: Initially screen point mutation panel (wait for batched run) __Yes__No</i> |
| <b>DMD/BMD:</b><br><input type="checkbox"/> Exon deletion<br><input type="checkbox"/> Carrier ( <b>required:</b> known mutation)<br><input type="checkbox"/> Linkage   |   |  |
| <input type="checkbox"/> <b>Thrombosis Panel (all 3)</b><br><input type="checkbox"/> Factor V Leiden<br><input type="checkbox"/> MTHFR<br><input type="checkbox"/> Prothrombin   |   | <b>Mitochondrial DNA Panels:</b><br><input type="checkbox"/> Panel 1 (point mutations)<br><input type="checkbox"/> Panel 2 – <b>Regular</b> (deletions)<br><input type="checkbox"/> Panel 2 – <b>Expanded</b> (deletions & duplications)   |

### CLINICAL INFORMATION

### PEDIGREE

### BILLING INFORMATION

- Direct payment (Cash, Check, Money Order)  
 Client (Specimen Submitting Facility) Billing: Provide exact billing address if different from above