impact genetics

LAB USE ONLY DO NOT FILL OUT

Date received: Y M D

Specimen type:

Condition:

MRN: Tech:

Form 1b: *Retinoblastoma Genetic Test Requisition*

Patient

Last name:

First name:

Date of birth: Y M D

Gender: ☐ Male ☐ Female

Pregnant: ☐ Yes ☐ No

Delivery date: Y M D

Patient History

☐ Affected

☐ Bilateral ☐ Unilateral ☐ Phenotype unknown

Diagnosis date: Y M D

☐ Unaffected

Family History

☐ Isolated case ☐ Positive family history

Family previously tested: ☐ Yes ☐ No

Mutation identified: ☐ Yes ☐ No

If mutation identified at lab other then Impact Genetics please provide report.

Proband name (first person in a family to be studied):

Mutation:

Relationship To Proband

☐ Proband ☐ Parent of proband

☐ Brother or sister of proband ☐ Child of proband

☐ Other:

Specimen Information

Sample:

- ☐ Blood sample for DNA
- ☐ Blood sample for RNA (at Impact Genetics' request)
- ☐ DNA from blood
- ☐ DNA from tumor
- ☐ Fresh tumor
- ☐ Frozen tumor
- ☐ Buccal swab (only for preapproved familial mutation confirmation, contact lab directly before submitting)
- ☐ Other:

Pre-natal:

- ☐ Cord blood ☐ CVS ☐ Cultured amniocytes
- ☐ Direct amniotic fluid ☐ DNA extracted from CVS
- ☐ DNA extracted from amniocytes

Date of collection: Y M D

Time of collection: HH:MM (24hr)

☐ Sample to test maternal cell contamination

☐ Tumor to follow

☐ No tumor to follow

Referring Specialist

Name:

Specialty:

Contact:

Telephone: Fax:

Email:

Signature:

Institution:

Address:

City: Prov/State:

Postal code: Country:

Additional copies to:

Email: Fax:

Pedigree

Billing

☐ a) Institution

Provide details:

☐ b) Patient Pay

*Complete **Form 1d:** Credit Card Authorization for Non-Covered Services.*

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e: info@impactgenetics.com *Please ensure to use secure email*

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