Advanced Genomics Laboratory (AGEN)

TEST REQUISITION FORM – Clinical Diagnostics

Children's Research Institute
A member of Children's Hospital and Health System.

Patient Information * REQUIRED *

Patient: First Name MI Last Name

Gender: ☐ Male ☐ Female ☐ Unknown

Ethnicity: ☐ Caucasian ☐ African American
☐ Asian ☐ Hispanic
☐ Other _____

Date of Birth (mm/dd/yy)

Medical Record Number

Mother's Name DOB (mm/dd/yy)

Father's Name DOB (mm/dd/yy)

Specimen Submitted:

	Patient	Mother	Father
EDTA Tube: (2 – 4 mL)	☐	☐	☐
Date Obtained:	_____ (mm/dd/yy)	_____ (mm/dd/yy)	_____ (mm/dd/yy)

Genetic Testing Panels

☐ DNA Deletion Duplication Array (DDDA)

☐ DMET Pharmacogenomics Testing (DMET)

☐ Quantitative PCR (qPCR)

Institution Contact/Report Address * REQUIRED *

INSTITUTIONAL BILLING ONLY

Contact Name

Institution

Institution Mailing Address

City/State/Zip Code

Phone Fax (Important)

Phyisician Signature

Physician Name (PRINTED)

Clinical Information * REQUIRED *

Indication for Test

☐ Birth Defect

☐ Mental Retardation

☐ Other Condition _____

Family member(s) affected: ☐ Yes ☐ No

Relationship(s) to affected individual

SPECIMEN DELIVERY ADDRESS

Send samples at room temperature to:

Medical College of Wisconsin
Advanced Genomics Laboratory
Attn: Rachel Lorier
TBRC / CRI Rm C2388
8701 Watertown Plank Road
Milwaukee, WI 53226
Website: www.mcw.edu/AGEN
Email: AGEN@mcw.edu

Phone: 414-955-2358 Fax: 414-955-6128

ADVANCED GENOMICS LABORATORY USE ONLY

Date Received: ____/____/____

Specimen Type: _____

Report Date: ____/____/____

Pre-Analytic Condition: ☐ Satisfactory ☐ Unsatisfactory

Deficiency Code: _____

Corrective Action: _____

Powerpath ID: _____