

## METABOLITE TEST REQUISITION FORM

*updated 6/25/18*

### PATIENT INFORMATION

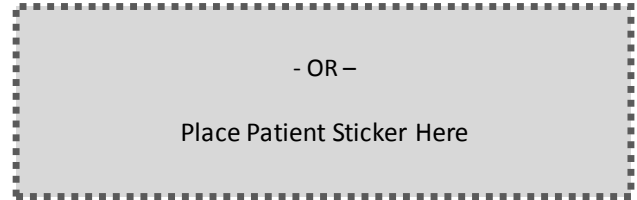
Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

DOB/Age: \_\_\_\_\_

Sex:  Male  Female

Medical Record #/Patient ID #: \_\_\_\_\_



### SPECIMEN INFORMATION

Accession/Lab ID #: \_\_\_\_\_

Specimen Type: \_\_\_\_\_

Specimen Date: \_\_\_\_\_ Time: \_\_\_\_\_

### PHYSICIAN INFORMATION

Ordering Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

### ADDITIONAL INFORMATION

Primary presenting symptoms: \_\_\_\_\_

Abnormal labs: \_\_\_\_\_

Suspected diagnosis: \_\_\_\_\_

Diet or infant formula: \_\_\_\_\_

Medication(s): \_\_\_\_\_

*If this space is not sufficient please attach clinical summary or patient history.*

### TEST(S) REQUESTED

- 5- Methyltetrahydrofolate - CSF
- Acylcarnitine profile - DBS, plasma, serum or whole blood
- Amino acids - plasma, serum or CSF
- Carnitine levels - DBS, plasma, or serum
- GABA (free and total) - CSF
- Homocysteine (total) - plasma or serum *(CSF is a research test)*
- Lactate - CSF
- Monoamine neurotransmitter metabolites - CSF\*
- Neopterin - CSF
- Organic acids - urine
- Tetrahydrobiopterin and neopterin - CSF\*

**\*Must be collected in Baylor CSF collection tubes**

### RESULTS INFORMATION

Name: \_\_\_\_\_

Results Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

### BILLING INFORMATION

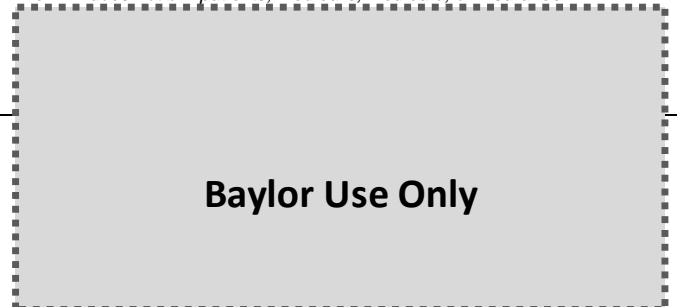
Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

*The IMD does not bill patients, Medicare, Medicaid, or insurance.*



Baylor Use Only

Demographic Entry Quality Check

Sample Process: \_\_\_\_\_

Testing Department: \_\_\_\_\_

Client Services: \_\_\_\_\_