

INSTITUTE OF METABOLIC DISEASE
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Dallas, TX 75226

Phone: (214) 820 – 4533
Fax: (214) 820 – 4853

MASS SPECTROMETRY AND TISSUE CULTURE
CLINICAL TEST REQUISITION FORM

Patient Name: _____
D.O.B./Age: _____ Gender: MALE FEMALE
Medical Record # or Patient ID #: _____

Specimen Information – Sample 1

Accession/Lab ID # _____
Specimen Type: _____
Sample Date: _____ Time: _____
For Cell Lines- Flask Date: _____
Passage #: _____

Specimen Information – Sample 2

Accession/Lab ID # _____
Specimen Type: _____
Sample Date: _____ Time: _____
For Cell Lines- Flask Date: _____
Passage #: _____

Ordering Physician: _____
Phone: _____ Fax: _____

NY State Clientele MUST check one of the following: Informed consent form for Genetic Testing enclosed, Informed consent form for Genetic Testing on file in Physician's office, Physician has signed or initialed above indicating that information regarding the nature of the Genetic Testing was conveyed to the patient. A Waiver from NY State has been obtained for the testing.

TEST(S) REQUESTED
(Please check all that apply for Sample 1)

TEST(S) REQUESTED
(Please check all that apply for Sample 2)

TO ASSIST INTERPRETATION PLEASE FILL IN BELOW

Primary Presenting Symptoms: _____

Abnormal Labs: _____
Suspected Diagnosis: _____
Diet or Infant Formula: _____
Medications: _____
(If this space is not sufficient please attach clinical summary or patient history)

- Mass Spectrometry tests:**
- Acylcarnitine Profile *
 - Carnitine Levels *
 - Organic Acids *
 - Fabry Disease Screening *

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- Tissue Culture tests:**
- Mitochondrial Beta Oxidation Defects

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*Please Note: For age related reference ranges, Date of Birth and Sample Date is required with each request.

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RESULTS ADDRESS

Phone: _____ Fax: _____

BILLING ADDRESS (The IMD does not bill patients, Medicare, Medicaid or insurance)

Phone: _____ Fax: _____