

INSTITUTE OF METABOLIC DISEASE
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Dallas, TX 75226

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**MOLECULAR DIAGNOSTICS
CLINICAL TEST REQUISITION**

PATIENT INFORMATION	
Patient Name: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
DOB or Age: _____	Hospital or Patient ID: _____
Accession #: _____	
SAMPLE INFORMATION	
Sample type: _____	If fibroblasts, flask date: _____ passage#: _____
Sample date: _____	Sample Time: _____

CLINICAL HISTORY:
Symptoms or Clinical findings: _____
Family history: _____

Ordering Physician: _____	Phone: _____	Fax: _____
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NY State Clientele MUST check AT LEAST 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:

- LCHAD DNA Analysis– [Common Mutation \(1528G>C\)](#)
- MCAD DNA analysis - [Common Mutation \(985A>G\)](#)
- MCAD DNA analysis – Panel of 8 mutations or individual mutation (check ALL for panel)
 - 244insT 583 G>A
 - 250C>T 616 C>T
 - 322-325 4bp del 617 G>A
 - 503 A>G 799 G>A
- MCAD DNA Analysis for individual known mutation. Indicate mutation: _____
- Unknown MCAD Mutation Analysis by DNA sequencing
- Salla DNA analysis – [Common mutation 115 C>T \(R39C\)](#)
- SASD Disease DNA Analysis for individual known mutation. Indicate mutation: _____
- Unknown SASD Mutation analysis by DNA sequencing of SLC17A5 gene

RESULTS ADDRESS	

Phone: _____	Fax: _____

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

Phone: _____	Fax: _____