INSTITUTE OF METABOLIC DISEASE
3812 Elm Street
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 #: ____________

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

Mass Spectrometry tests:

☐ Acylcarnitine Profile *
☐ Carnitine Levels *
☐ Organic Acids *

Tissue Culture tests:

☐ Mitochondrial Beta Oxidation Defects

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

Specimen Information – Sample 2

Accession/Lab ID # ______________

Specimen Type: ______________

Sample Date: __________ Time: ________

For Cell Lines- Flask Date: ____________

Passage #: ____________

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

Mass Spectrometry tests:

☐ Acylcarnitine Profile *
☐ Carnitine Levels *
☐ Organic Acids *

Tissue Culture tests:

☐ Mitochondrial Beta Oxidation Defects

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

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.

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)

RESULTS ADDRESS

____

____

____

Phone: Fax:

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

____

____

Phone: Fax: