



MOLECULAR DIAGNOSTICS LABORATORY UT HEALTH SAN ANTONIO

Dpt. of Pathology & Lab Medicine
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(210) 450-2243 (Fax)
<http://pathology.uthscsa.edu/stl/molecular/index.shtml>

Do not write in this space

MDL#

Request for Molecular Diagnostic Studies

Patient's Name: _____ DOB/Age: _____ Sex: _____ Ethnicity: _____
First (Middle Initial) Last

Ordering Facility: _____ Address: _____
Street City State Zip

Hospital/Pt ID#: _____ Diagnosis: _____

Specimen Submitted: _____ Fresh Frozen Paraffin Other

Specimen #: _____ Specimen Collection Date: _____ Collection Time: _____

Requesting Physician (required): _____ Telephone: _____ Fax: _____

Physician Address: _____
Street City State Zip

Additional reports to: _____
Name Address Fax Tel

Pertinent clinical history, diagnosis, and laboratory data: _____

Has informed consent been obtained for genetic testing? Yes No

Patient previously tested in our laboratory? Yes No Unknown

Tests Requested (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> IGH clonality detection by PCR and capillary electrophoresis | <input type="checkbox"/> BCL2 translocation t(14:18) by PCR major breakpoint |
| <input type="checkbox"/> IG kappa clonality detection by PCR and capillary electrophoresis | <input type="checkbox"/> Detection of <i>JAK2</i> V617F mutation |
| <input type="checkbox"/> TCR gamma clonality detection by PCR and capillary electrophoresis | <input type="checkbox"/> Factor V (<i>F5</i>) Leiden (R506Q) |
| <input type="checkbox"/> TCR beta clonality detection by PCR and capillary electrophoresis | <input type="checkbox"/> Prothrombin (<i>F2</i>) G20210A mutation |
| <input type="checkbox"/> Quantitative <i>BCR/ABL</i> (p210 and/or p190) by real-time PCR | <input type="checkbox"/> Neisseria gonorrhoeae &/or Chlamydia trachomatis NAA assay |
| <input type="checkbox"/> <i>PML/RARα</i> translocation t(15:17) by real-time PCR | <input type="checkbox"/> Human Papillomavirus (HPV) NAA Assay |
| <input type="checkbox"/> Hereditary hemochromatosis (C282Y and H63D by PCR & RFLP) | <input type="checkbox"/> Other (specify) _____ |
| | <input type="checkbox"/> |

Note: Specimens will not be processed without billing information

Bill Patient: _____
Address Phone

Bill Facility: _____
Facility Name and Address Patient ID#

Bill Insurance: _____
Insurance Company Name and Address

Name of Insured Policy # Group #

Patient Address Telephone # Date of Birth

Bill Research Account: _____
Principal Investigator Account #