Duchenne/Becker Muscular Dystrophy (DMD/BMD)

Deletion/Duplication and Sequencing Test

University of Utah Genome Depot
15 North 2030 East
Eccles Institute Human Genetics (EIHG) Room 2260
Salt Lake City, UT 84112-8934
Contact: Diane Dunn (Laboratory Supervisor)
Email: ddunn@genetics.utah.edu
Phone 801-585-3436 FAX 801-585-7177

DNA TEST REQUISITION FORM

CLIA #

46D1010280

Please Print Clearly

Requesting Laboratory Information for Invoicing

Hospital/Lab Name:_____ **Contact Name:**_____

Address:_____ **City, State Zip:** _____

Phone Number: _____ **FAX number:** _____ **E-Mail:**_____

Ordering Physician:_____ **Phone Number:**_____ **FAX number:** _____

Address:_____ **City, State Zip:** _____

Additional Person to release Information: Name:_____

Address:_____ **City, State Zip:** _____

Test Information

Date of specimen collection _____

Specimen preparation and shipping: yellow top ACD or purple top EDTA tubes containing whole blood samples or genomic DNA (at least 2 µg) should be sent via courier at room temperature with this form enclosed. Shipping instructions are available at www.genome.utah.edu/duchenne-becker-muscular-dystrophy

Patient Information

Name Last:_____ **Name First:**_____ **Middle:**_____ **Male** ☐ **Female** ☐ **Date of Birth:**_____

Address:_____ **Identification Number:**_____ **Check One:** ☐ **Symptomatic** ☐ **Carrier** ☐ **Pre-Symptomatic**

Obligation

1. The authorizing physician is obliged to explain this testing and provide genetic counseling. The DNA Testing Consent Form must be signed by the patient and the physician (or genetic counselor).
2. The test results will be returned to the requesting physician. Please contact the referring physician after six weeks.

Additional Information

Family history information: _____

Patient Ethnicity _____ Diagnosis made by: Check all that apply ☐ Clinical Features ☐ Elevated serum CK ☐ X-Linked History ☐ Biopsy

PAYMENT INFORMATION

Payment is the responsibility of the patient or patient's family. The University of Utah Dept. of Human Genetics does not bill insurance companies, but will issue a receipt. Payment by check or credit card only. Payment must be in US dollars.

DMD Gene Test Requested and Changes by Deletion/Duplication Status

1 ☐ Stepwise mutation analysis for patients without previous testing.

Part 1. Deletion/Duplication MLPA Testing.....**$ 500**
Part 2. Follow-up Sequencing (additional charges).....**$ 700**

By checking box #1 you authorize us to bill your credit card $1,300, if needed, to complete both tests.
If you are paying by check submit a check for $500; we will notify you if further payment is required.

2 ☐ Deletion/Duplication MLPA Testing .....**$ 500**

3 ☐ Direct sequencing analysis of the dystrophin gene .....**$ 800**

4 ☐ Sequencing of a single exon—for patients with previously identified mutation*** .....**$ 400**

5 ☐ Female Carrier Testing for a deletion or duplication*** .....**$ 500**

***Please include a copy of the analysis identifying the family member's mutation.

PATIENT PAYMENT - CREDIT CARD ☐ **INSTITUTION/FACILITY/LAB BILLING** ☐

Security Code_____ Credit Card (circle one) Visa / Mastercard Credit Card # _____ Expiration Date_____

Authorized Signature _____ Date:_____

By signing above you authorize the University of Utah Genome Center to deposit your check or process you credit card, as indicated above, for charges for this testing. (PLEASE NOTE: NO PAYMENT WILL BE PROCESSED UNTIL COMPLETITION OF TESTING)

DNA TEST REQUISITION FORM

Consent for Diagnostic DNA Testing
University of Utah
Department of Human Genetics
Patient's Name: _____Date of Birth:_____
The blood or tissue sample I (my child) have (has) provided is required to isolate DNA with which to undertake molecular genetic testing at the University of Utah, Department of Human Genetics.

- The molecular genetic testing may provide a diagnosis of or indication of risk for myself or my offspring for he condition specified above.
- I understand that this test may not yield results for any combination of the following reasons: 1) The causative mutation may not be detected; 2) Unforeseen technical reasons.
- I understand that a physician's order is necessary for testing, and that the results will be returned to the ordering physician or laboratory.
- In the case of carrier testing, I understand that in rare cases gene testing of DNA from blood may fail to detect mutations carried in the parental germ-line (ovaries and testes). Because of this I understand that a negative test report cannot absolutely exclude the possibility that I am a carrier.
- I understand that the procedure used to collect the blood or tissue samples has inherent minimal risks which have been explained to me (my child).
- An additional blood or tissue sample may have to be obtained or if the results are inconclusive, or due to unforeseen circumstances
- My (my child's) DNA will be stored in the DNA bank at the University of Utah, Dept. of Human Genetics, Salt Lake City or its responsible delegate
- I **DO** ☐ **DO NOT** ☐ **Initial** _____ agree to allow my (my child's) DNA samples to be used for the purpose of diagnosis, research and development, or quality control at the laboratory. I understand that any information identifying me (my child) will be kept confidential and that any exchange of samples or information will be coded.
- No compensation will be given to me (my child) nor will funds be forthcoming to me (my child) due to invention resulting from research and development using my (my child's) DNA.

Your signature on this form indicates that you have understood to your satisfaction the information regarding molecular genetic testing and agree to participate. If you have further questions concerning matters related to this consent, please discuss them with your medical geneticist, genetic counselor, or referring physician. For other questions, please contact Diane Dunn at 801-585-3436.

_____ _____
Signature of patient or legal guardian **Date**

_____ _____
Signature of witness **Date**

Physician's/Counselor's Statement: I have explained DNA testing to this individual. I have addressed the limitations outlined above and I have answered this person's questions. I will provide appropriate genetic counseling regarding the results

_____ _____
Signature of physician or genetic counselor **Date**