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

Spinocerebellar ataxias

CAG Repeat Expansion Tests

Requesting Laboratory Information for Invoicing

Please Print Clearly

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:** _____

Date of specimen collection _____

Test Information

Specimen preparation and shipping: yellow top ACD or lavender 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/spinocerebellar-ataxia-repeat-expansion-panel

Patient Information

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

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

Obligation

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).The test results will be returned to the requesting physician. Please contact the referring physician after four weeks.

Additional Information

Family history information: _____

Patient Ethnicity _____ Diagnosis made by: Check all that apply ☐ Symptomatic ☐ Early onset ☐ Known mutation ☐ Pre-symptomatic

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.

CAG Repeat Expansion Test Requested

1 ☐ Spinocerebellar Ataxia Repeat Expansion Panel (SCA1, SCA2, SCA3, SCA6, SCA7 and SCA17): .....**$ 550**

2 ☐ Individual repeat expansion test for SCA1, SCA2, SCA3, SCA6, SCA7, SCA17 or SBMA (circle one): .....**$ 400**

3 ☐ Testing for family members of patients with previously detected mutations:*** .....**$ 300**

Gene and expansion mutation description:

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

Payment/Billing Information

Check Number _____ Credit Card (circle one) Visa/MC Card # _____ Exp Date _____ Sec. Code _____

Authorized Signature _____ Date _____

By signing the 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.

☐ Bill laboratory/institution (must be listed at top of form). Contact information if different than above:

_____

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**