

**LAB REQUISITION**  
**Molecular Development Laboratory**  
**Dept. of Pediatrics, University of Washington**

CLIA # 50D1058955

**SEND ONE REQUISITION FOR EACH SAMPLE SUBMITTED:**

|  |                           |
|--|---------------------------|
| <b>Name (Last, First):</b>   | <b>DOB:</b>               |
| <b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female   | <b>Date Sample Drawn:</b> |
| <b>Ethnic Background:</b> <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> European Caucasian<br><input type="checkbox"/> Hispanic <input type="checkbox"/> Native American |                           |

**REPORT RESULTS TO:**

**BILL TO:** Reference # (if applicable): \_\_\_\_\_

|                            |  |
|----------------------------|--|
| Referring Physician / Lab: | Referring Physician / Lab (we are <u>unable</u> to bill patient or patient's insurance): |
| Hospital / Institution:    | Hospital / Institution:  |
| Address:                   | Address:   |
| City, State Zip:           | City, State Zip:   |
| Tel:                       | Tel:   |
| Fax:                       | Fax:   |
| E-Mail:                    | E-Mail:  |

**TESTS TO BE PERFORMED** (Sequencing Analysis):

- CONGENITAL SUCRASE-ISOMALTASE DEFICIENCY (CSID)**
- S/ entire coding region
  - Panel for 4 common mutations
  - Circumpolar 5-mutation panel: the 4 common mutations plus c.273\_274delAG
  - Known mutation analysis \_\_\_\_\_, \_\_\_\_\_
- GAUCHER DISEASE**
- GBA entire coding region
  - Mutation panel for 4 common mutations
  - Known mutation analysis \_\_\_\_\_, \_\_\_\_\_
- ICGG Registry # (if applicable): \_\_\_\_\_

**TYPE OF SAMPLE YOU ARE SENDING:**

- Whole Blood (minimum of 3 cc in lavender EDTA or yellow ACD tubes)
- Blood Spots
- Other \_\_\_\_\_

**INDICATION FOR TESTING:**

- Symptomatic
- Family history
  - Prenatal testing
  - Carrier testing
  - Known mutation testing
- Please provide clinical history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SHIPPING INFORMATION:**

Whole blood sample should be drawn Monday through Thursday and shipped the same day for OVERNIGHT DELIVERY, in a spill-proof kit, labeled biohazard, at room temperature. Samples must be received from Monday through Friday.

**SHIPPING ADDRESS:**

Molecular Development Lab  
Dept. of Pediatrics, Mailstop 356320  
University of Washington  
1959 NE Pacific St, Room RR-335 HSB  
Seattle, WA 98195-6320  
tel: +1.206.543.3370

Enzyme activity: \_\_\_\_\_