



Clinic for Special Children
 PO Box 128, 535 Bunker Hill Road
 Strasburg, Pennsylvania 17579
 Phone: 717-687-9407, Fax: 717-687-9237

Laboratory Requisition Form

Section A

Patient:	Birthdate:
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Section B

Sample:	<input type="checkbox"/> Venous blood	<input type="checkbox"/> Serum/plasma	<input type="checkbox"/> Filter paper	<input type="checkbox"/> Urine
	<input type="checkbox"/> Cord blood	<input type="checkbox"/> Other _____		

Section C

Tests: <input type="checkbox"/> Amino acid quantitation by HPLC <input type="checkbox"/> Organic acid analysis by GC/MS <input type="checkbox"/> Targeted mutation detection * (see Mutation List)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding-right: 5px;">Disease</td> <td style="border: 1px solid black; height: 25px;"></td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;">Gene</td> <td style="border: 1px solid black; height: 25px;"></td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;">Mutation</td> <td style="border: 1px solid black; height: 25px;"></td> </tr> </table>	Disease		Gene		Mutation	
Disease							
Gene							
Mutation							
* All molecular genetic testing MUST be accompanied by signed consent forms.							

Section D

Referrer:	<input type="checkbox"/> Physician	<input type="checkbox"/> Midwife	<input type="checkbox"/> Genetic counselor	<input type="checkbox"/> Other
Name:				
Institution:				
Address:				
City:		State:		Zip:
Telephone:			Fax:	
Reporting: Please provide one address and/or fax number for test reporting.				
Name:				
Institution:				
Address:				
City:		State:		Zip:
Telephone:			Fax:	
Billing: Please provide an address for billing purposes (if different from Reporting , above).				
Name:				
Institution:				
Address:				
City:		State:		Zip:
Telephone:			Fax:	