Children's Hospital of Philadelphia℠

LAB-1602
Rev. 2/24

LAST NAME | FIRST NAME

MR# | DOB

PLACE PATIENT LABEL HERE *OR* COMPLETE ABOVE

DO NOT HANDWRITE PATIENT INFORMATION HERE

Division of Genomic Diagnostics
LIQUID BIOPSY TEST REQUISITION

SHIP TO: Children's Hospital of Philadelphia, Genomic Diagnostic Laboratory, 3615 Civic Center Blvd., Abramson Research Center, 714J, Philadelphia, PA 19104-4302 - Phone: (267) 426-1447

PATIENT INFORMATION

Patient Name (Last, First, Middle):

Ordering Facility MRN:

Sex: ☐ Male ☐ Female ☐ Unknown ☐ Other: _____

Date of Birth (Month/Day/Year): _____

Phone Number: (_____)_____

Street Address: _____

City/State: _____

Zip/Country: _____

Race/Ethnicity:

☐ Amish ☐ Asian ☐ Black/African-American
☐ Caucasian ☐ East Indian ☐ French Canadian
☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic
☐ Mediterranean ☐ Native American
☐ Other: _____

SAMPLE INFORMATION

Specimen Collection Date (Month/Day/Year):

Patient disease status:
☐ Active ☐ Remission ☐ Relapse
☐ Other: _____

Diagnosis:
☐ Neuroblastoma ☐ Other: _____

Date of original tumor diagnosis (MM/YY):

Does the patient have a bone marrow transplant? ☐ Yes ☐ No

Are relevant prior testing reports (including *MYCN* status) available?
☐ Yes (please attach) ☐ No

ORDERING PROVIDER

Name (Last, First, Degree)

(_____) _____
Phone

(_____) _____
Fax

Institution

Street Address

City State

Zip Country

Email

ORDERING LABORATORY

Name (Last, First, Degree)

(_____) _____
Phone

(_____) _____
Fax

Institution

Street Address

City State

Zip Country

Email

OTHER ORDERING PROVIDER / GENETIC COUNSELOR

Name (Last, First, Degree)

(_____) _____
Phone

(_____) _____
Fax

Email

For Lab Use Only
Type of billing: ☐ Institutional ☐ CHOP ☐ Self-pay ☐ Institution called
Comments:

Received by: Received Date: Received Time: Sample:

Phone: (267) 426-1447; Fax: (215) 590-3514; Email: dgdgeneticcounselor@chop.edu;
Website: http://www.chop.edu/centers-programs/division-genomic-diagnostics

*Testing will not be initiated until all necessary samples and clinical information are submitted to the laboratory.

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TEST INFORMATION

☐ Neuroblastoma Liquid Biopsy (Circulating tumor DNA)

GENE CONTENT	
Neuroblastoma Liquid Biopsy Panel	Sequence analysis of: *ALK*, *ARID1A*, *ARID1B*, *ATRX*, *BRAF*, *CDK4*, *CDKN2A*, *CDKN2B*, *CIC*, *ERBB2*, *FGFR1* (NM_023110, exons 9-19), *HRAS*, *KRAS*, *MDM2*, *MET*, *MYCN, NF1*, *NRAS*, *PHOX2B, PTPN11, SMARCA4* (NM_001128847.1, exons 16-19, 24, and 25), *TERT* (NM_198253, promoter region), and *TP53* Presence or absence of *MYCN* amplification is analyzed and reported.

Sample Requirements

Collect peripheral blood in cell-free DNA (cfDNA) blood collection tubes (Streck). Collect 2 tubes total with 10ml in each tube. Minimum acceptable volume is 5ml per tube. Deliver within 24 hours at room temperature. **Do not refrigerate or freeze.**

Shipping Instructions

Samples should be shipped by overnight carrier to arrive Monday-Friday (9am-5pm) only. Samples should be sent at ambient (room) temperature. Avoid extreme temperatures.

Shipping address –

Children's Hospital of Philadelphia
Genomic Diagnostics Laboratory
3615 Civic Center Blvd.
Abramson Research Center, 714J
Philadelphia, PA 19104-4302
Phone: (267) 426-1447

Necessary Documents

Each sample should be sent with a completed **Test Requisition Form**, including billing information, and **Consent Form** (if applicable).

Results from Prior Testing – Please include results from prior genetic testing or other related reports that may provide necessary information for genetic testing.

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Billing Options (For Non-CHOP patients only)

***By using and sending this Requisition Form to CHOP Outreach Lab for laboratory testing, you, the sender, acknowledge and agree that you have read and agree to the CHOP Terms and Conditions posted at www.chop.edu/labs and agree to pay CHOP the rates in CHOP's fee schedule in effect on the date the specimen is received.**

Institutional Billing Option

ICD-10 Diagnosis Codes for Billing: _____

Bill to Institution/Department: _____

Address: _____

_____

Billing Contact: _____

Phone: _____ Fax: _____

Email: _____

Please provide FedEx number to use for return shipment if requested: _____

Self Pay Option

Total Cost Approved: _____ Credit Card: ☐ Visa ☐ American Express ☐ Discover ☐ MC

Name on Card: _____

Cardholder Date of Birth: _____
Month/Day/Year

Card Number: _____

Expiration Date: _____ CCV (security # on back): _____
Month/Year

Billing Address: _____

_____

Phone: _____ Email: _____

_____
Cardholder Signature Printed Name Date (Month/Day/Year) Time

*Cardholders signature indicates authorization to bill Credit Card