Children's Hospital of Philadelphia®
Palmieri Laboratory for Metabolic & Advanced Diagnostics

The Palmieri Laboratory for Metabolic & Advanced Diagnostics
Room 5NW55 Main
3401 Civic Center Blvd, Philadelphia, PA 19104
Phone: 215-590-3394 Fax: 215-590-1998
email: MetabolicLab@chop.edu
https://www.chop.edu/centers-programs/metabolic-and-advanced-diagnostics

Patient Information

Last Name: _____

First Name: _____

Patient ID / Med Rec #: _____

DOB: _____

Gender: ☐ Male ☐ Female ☐ Unknown

Physician Name: _____

Physician Phone: _____

Physician Signature: _____

Reference Laboratory Billing Information

WE DO NOT BILL PATIENTS OR THEIR INSURANCE COMPANIES

Institution: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Name: _____

Phone: _____ Fax: _____

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 in received.

Required Information for New York State Patients

One of these must be checked or testing will not be performed

☐ Informed Consent for Genetic Testing is on file in Physician's Office

☐ Physician has initialed that consent for Genetic Testing was discussed with Patient.

Initials: _____ Date: _____

Required for all NJ & PA Newborn Screening Patients

Please Check the Appropriate State Screening Program Information

☐ NJ NBS Program ☐ Initial Testing ☐ Continued Monitoring

☐ PA NBS Program ☐ Initial Testing ☐ Continued Monitoring

Clinical Information (Required for NBS Patients / Suggested for All Others

1. **Presumptive Diagnosis:** _____
2. **ICD-10 Code:** _____
3. **Other Abnormal Findings:** _____
4. **Medication:** _____

Specimen Information (only one Sample Type per requisition)

Type: ☐ Blood (B) ☐ Plasma (P) ☐ Serum (S) ☐ Protein Free Blood (PB) ☐ Protein Free CSF (PC) ☐ CSF (C)

☐ Urine (U) Random Timed ☐ Duodenal Biopsy (DB) ☐ Washed Red Blood Cells (wRBC) ☐ Cultured Fibroblasts (F)

Collection Date: _____ **Collection Time(s):** _____ **Your Lab Number:** _____

Testing Requested

Amino Acid Quantitation	☐ P	☐ S	☐ U	☐ CSF
Acylcarnitine Profile	☐ P	☐ S		
Carnitine (Total & Free)	☐ P	☐ S		
Infliximab	☐ P	☐ S		
Methylmalonic Acid Quantitation	☐ P	☐ S		
N-glycan	☐ P	☐ S		
Carbohydrate Deficient Transferrin	☐ P	☐ S		
Ketone Body Panel	☐ B	☐ S		
Glutathione	☐ B-EDTA		☐ Kit	
Pyruvate-Lactate			☐ Kit	
OxPhos	☐ F			

Testing Requested

Epimerase Enzyme Activity	☐ B	☐ wRBC
Gal1PO4 Uridyltransferase (GALT) Activity	☐ B	☐ wRBC
Gal1PO4 Analysis	☐ B	☐ wRBC
Galactokinase Enzyme Activity	☐ B	☐ wRBC
Disaccharidase Analysis	☐ DB	
Galactitol Analysis	☐ U	
Organic Acid Analysis	☐ U	☐ CSF
Ortoic Acid Quantiitation	☐ U	
MPS and Oligosaccharides	☐ U	

***Note: Samples for Galactosemia testing should be shipped Monday through Thursday and within 24 hours of collection. Samples for Disaccharidase testing should be shipped Monday through Thursday and severe weather, please see test description list for specific handling instructions and contact the lab.
Ketone Body Panel Blood needs to be spun down immediately in Gold Tube and Frozen. If collected in Red Top Tube, spin down immediately and collect serum and freeze serum immediately.
Forallother samples,see testdescriptionlistforspecifichandlinginstructions.

Please email tracking information to: SpecimenTracking@chop.edu.