Children's Hospital of Philadelphia

LAB-1602
Rev. 2/24

Division of Genomic Diagnostics
LIQUID BIOPSY TEST REQUISITION

LAST NAME ______ FIRST NAME ______
MR# ______ DOB ______

PLACE PATIENT LABEL HERE *OR* COMPLETE ABOVE

DO NOT HANDWRITE PATIENT INFORMATION HERE

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 results (including *MYCN* status) available?
☐ Yes (please summarize below or attach report) ☐ No

Results Summary: ______

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.

Division of Genomic Diagnostics
LIQUID BIOPSY TEST REQUISITION

TEST INFORMATION

☐ Neuroblastoma Liquid Biopsy (Circulating tumor DNA)

GENE CONTENT

Neuroblastoma Liquid Biopsy Panel	Regions of interest: *ALK*, *ARID1A*, *ARID1B*, *ATRX*, *BRAF*, *CDK4*, *CDKN2A*, *CDKN2B*, *CIC*, *ERBB2*, *FGFR1* (NM_023110, exons 9-19), *HRAS*, *KRAS*, *MDM2*, *MET*, *MYCN* (NM_005378, partial exon 3 for copy number analysis only), *NF1*, *NRAS*, *PHOX2B, PTPN11, SMARCA4* (NM_003072 exons 17-20, 25 and 26), *TERT* (NM_198253, promoter region), and *TP53* Sequence analysis of all exons and the flanking intronic sequences of the genes listed are included unless otherwise specified. *MYCN* is only analyzed for copy number changes and reported as the presence or absence of *MYCN* Amplification. Sequence analysis of *MYCN* is not performed.

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.

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

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