

University California

Ophthalmic Molecular Diagnostic Laboratory

Voice (858) 534 5362 Fax (858) 246 0568 eyeDNAtest@ucsd.edu

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MOLECULAR TEST REQUEST

Patient Name _____
 Last First Middle
 DOB Sex Race/ethnicity

CHECK EACH TEST BEING ORDERED:

If ordering more than one test please specify the order that you would like the test run (for example: ABCA4-1st, ELOVL4-2nd). If requested in this way, we will only run the second test if the first does not yield informative results. If you are requesting two tests and would like them run simultaneously, please number them both 1st (for example, ABCA4-1st, ELOVL4-1st). In general, we have enough DNA from a single blood sample to run more than one test. We would contact you if we do not have sufficient DNA to run both of the tests. Please be sure that the patient is appropriately consented for more than one test if you are requesting more than one test.

<u>Gene</u>	<u>Related Eye Disease</u>	<u>Gene</u>	<u>Related Eye Disease</u>
____ ABCA4	Stargardt's Macular Degeneration	____ Bestrophin	Best's Macular Degeneration
____ EFEMP1	Malattia Leventinese/ Doyme Honeycomb Dystrophy	____ ELOVL4	Dominant Stargardt-like Macular Degeneration
____ RDS	Pattern Dystrophy, Butterfly Macular Dys, Adult-onset Foveomacular Dys, Bull's Eye Maculopathy, Late-onset Dominant Macular Deg Additional RDS phenotype _____	____ TIMP3	Sorsby's Fundus Dystrophy
____ RHO	Dominant Retinitis Pigmentosa	____ CRX	Dominant Cone-Rod Dys
____ CEP290	Recessive LCA	____ CRB1	Recessive Retinitis Pigmentosa with Para-arteriolar preservation of the RPE (PPRPE); Leber congenital amaurosis
		____ CTRP5	Late-onset Dominant Macular Dys
		____ RPE65	arRP, LCA

REFERRAL SOURCE

Requesting Clinician: _____

Requesting Facility _____

Address: _____

Phone #: _____ Fax#: _____ Email: _____

REPORTING INFORMATION (Results will be released only to qualified medical personnel.)

Send report to: _____

Address: _____

Phone #: _____ Fax#: _____ Email: _____

Signed consent forms must be included for all blood samples submitted.**LAB USE ONLY**

Sample #: _____

Date/Time Received: _____

Specimen Type: _____

Initials: _____

Patient Name _____
Last First Middle

Payment information *Payment must accompany sample, for more information see page 5.*

Cost of Testing: \$2500 for ABCA4, \$850 all other genes, 350\$ for familial mutation screening and No charge for Parental samples. We do not bill patient’s insurance or patient directly.

Form of payment:

- Check/Money Order _____
- Credit Card Number _____ Exp. Date _____
Name on Card _____

For Credit Card payments, charge will appear on statement as “UCSD Medical Group”.

For check and credit card payments, please specify contact information for person responsible for payment.

Name: _____ Phone Number: _____

- Institutional Billing

Contact person for billing: _____ Phone Number: _____

Address where bill should be sent: _____

ENCLOSE SUMMARY OF OCULAR EXAMINATIONS AND TESTING

CLINICAL DATA/INDICATION FOR REFERRAL

(Check only one)

- _____ Patient has signs/symptoms of disease
Diagnosis/Possible Diagnosis _____
Age @ dx _____
Current visual activity _____
- _____ Based on family history, patient is at risk for disease but does not have signs/symptoms
Diagnosis in family _____
- _____ Other
Describe _____

Family History Information

Please include or complete the pedigree below with the sample:

- Include information on diagnosis and age at diagnosis for all with eye disease
- Indicate any relatives who have had molecular testing for eye disease

Have other family members previously submitted samples to a lab for ophthalmic disease testing?

_____yes _____no _____unknown, explain (adopted, etc) _____

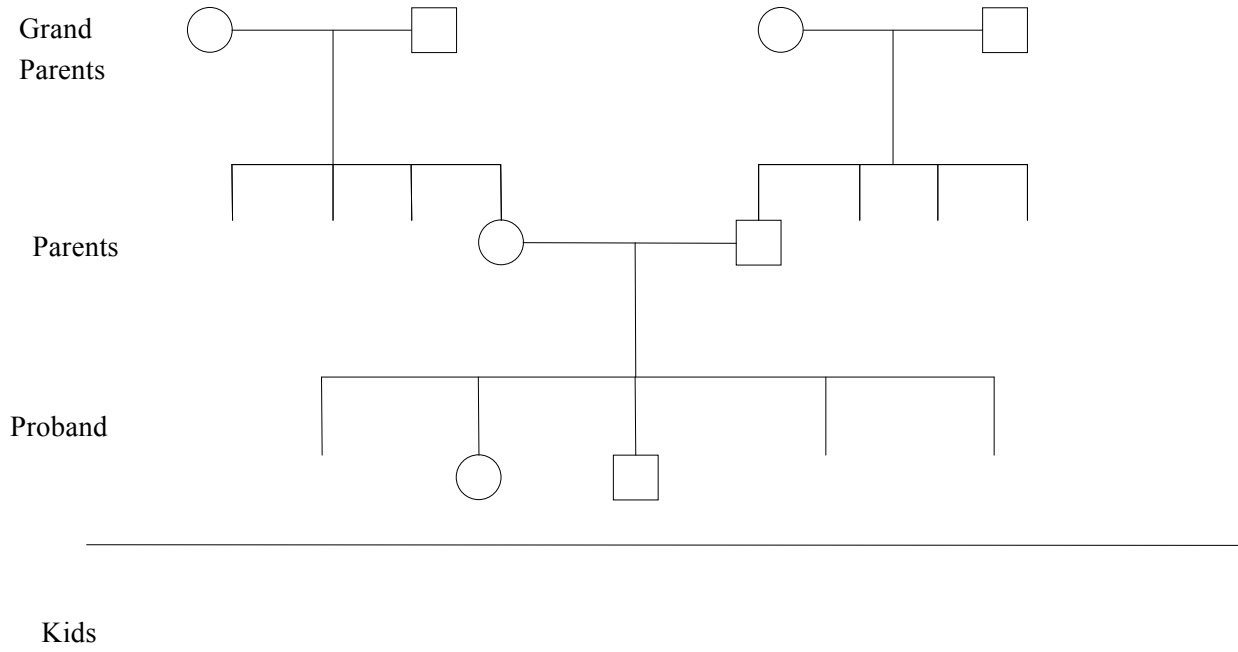
Name of lab: _____

Mutation identified: _____

We encourage you to submit blood samples from parents of the person requesting testing or an affected relative. Signed consent forms must be included for all blood samples. These samples will be used to confirm inheritance of disease genes, however, these additional family members will not receive results on their samples.

Maternal Ethnicity :

Paternal Ethnicity:



Additional Comments/ Family History:

Blood Sample Drawing and Shipping Requirements:

- Please draw the following amount in a EDTA tube (lavender top) Adults: 7-9 ml Child: 5-7 ml
- Label each tube with patient's full name, birth date and date blood drawn. Keep all samples at room temperature. Do not ship on ice or dry ice.
- Notify lab prior to shipping sample
858-534-5362 *Monday-Thursday, 8am-5pm, pacific time*
- Overnight delivery requested. Samples received more than 72 hours after collection will not be accepted.
- Deliveries accepted only Monday-Friday; no Saturday deliveries.

Please note

- Any sample obviously contaminated with microorganisms will not be accepted.
- Blood samples received greater than 72 hours after draw will not be accepted.
- Damaged or leaking containers and clotted blood samples will be reported to the sender immediately. This may result in decreased DNA yields and may make analysis impossible. In this case, a second sample may be required before analysis can begin.
- Samples will not be accepted directly from patients. All contact with the laboratory must be through the requesting medical professional.

Sample must be accompanied by:

- Completed Molecular Test Request (3 pages)
- Summary of ocular examinations and testing
- Completed Pedigree
- Signed DNA consent form
- Payment
- Completed research consent form

Place forms in a plastic bag separate from the sample. Please inform the lab prior to shipping the samples either by email or phone.

**SHIP TO: The Ophthalmic Molecular Diagnostics Laboratory
The University of California
Attention: Harini Gudiseva
Room 236, Shiley Eye Center
9415 Campus Point Drive
La Jolla, CA 92037.
Tel: 858-534-5362 Fax: 858-246-0568**

Reporting information Results will be released only to qualified medical personnel identified in the Molecular Test Request.

Turn-around time 12 weeks; may be longer during holiday periods.

Cost ABCA4 test \$2500
Other tests \$850
Familial Mutation detection \$350

CPT codes 83894 (separation by gel electrophoresis)
83898 (PCR amplification of DNA, each primer paired)
83891 (extraction of highly purified nucleic acid)
83904 (mutation identification by sequencing)
83912 (interpretation and report)

Payment **We do not bill insurance or patient directly. All samples must be accompanied by payment in full for the testing.** No analysis will be initiated without payment.

Check/Money Order: Make check or money order payable to *University of California-Regents*

Institution Direct Billing: Referring institutions and physicians may establish institutional accounts.
Contact: eyednatest@ucsd.edu

CONTACT INFORMATION:

The Ophthalmic Molecular Diagnostics Laboratory
The University of California, Shiley Eye Center
Attention: Harini Gudiseva M.S, CLSp (MB)
Molecular genetic studies coordinator,
Room 236, Shiley Eye Center
9415 Campus Point Drive
La Jolla, CA 92037.
Voice mail 828-534-5362 Fax 858-246-0568
Email: eyednatest@ucsd.edu
Website: <http://www.eyesite.ucsd.edu/genetics/index.htm>