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.

Gene	Related Eye Disease	Gene	Related Eye Disease
_____ ABCA4	Stargardt's Macular Degeneration	____ Bestrophin	Best's Macular Degeneration
_____ EFEMP1	Malattia Leventinese/ Doyne 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
		____ CRX	Dominant Cone-Rod Dys
		____ CRB1	Recessive Retinitis Pigmentosa with Para-arteriolar preservation of the RPE (PPRPE); Leber congenital amaurosis
	_____	___ CTRP5	Late-onset Dominant Macular Dys
_____ RHO	Dominant Retinitis Pigmentosa	___ RPE65	arRP, LCA
_____ CEP290	Recessive 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 #:_____ **Specimen Type:**_____
Date/Time Received:_____ **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: _____

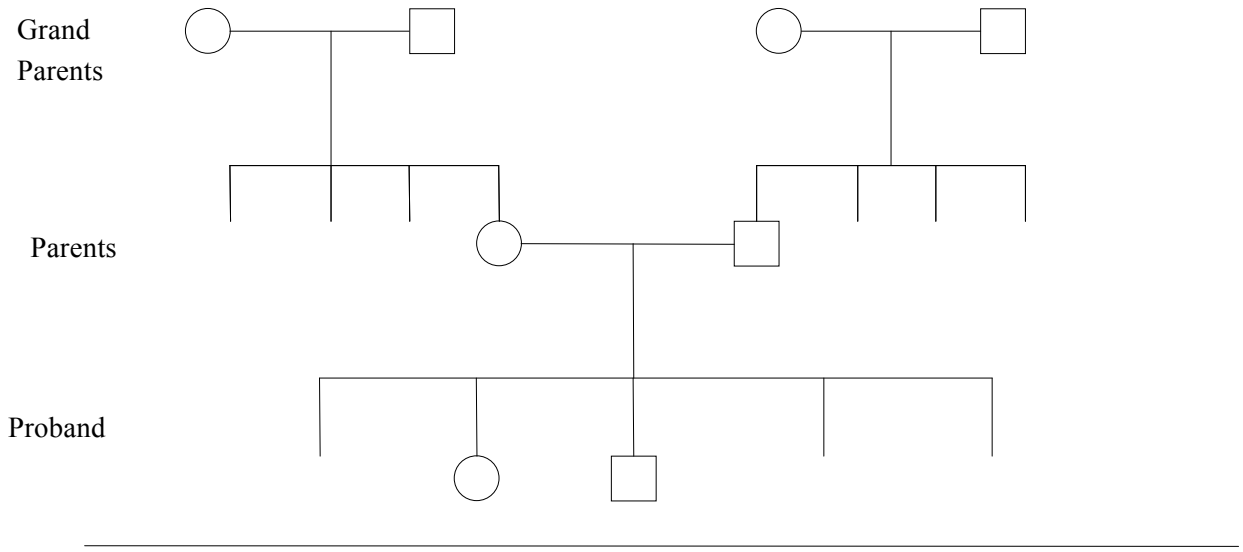
Mutation identified: _____

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.

PAGE #3 RETURN WITH SAMPLE

Maternal Ethicicity :

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