MOLECULAR DIAGNOSTICS LABORATORY

UT Health San Antonio

Dept. of Pathology & Lab Medicine
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http://pathology.uthscsa.edu/strl/molecular/index.shtml

Do not write in this space

MDL#

Request for Molecular Diagnostic Studies

Patient's Name: _____ DOB: _____ Sex: ____ Ethnicity: _____
First (Middle Initial) Last

Ordering Facility: _____ Address: _____
Street City State Zip

Hospital/Pt ID#: _____ Diagnosis: _____

Specimen Submitted: _____ ☐ Fresh ☐ Frozen ☐ Paraffin ☐ Other

Specimen #: _____ Specimen Collection Date: _____ Collection Time: _____

Requesting Physician (required): _____ Telephone: _____ Fax: _____

Physician Address: _____
Street City State Zip

Additional reports to: _____
Name Address Fax Tel

Pertinent clinical history, diagnosis, and laboratory data: _____

Has informed consent been obtained for genetic testing? ☐ Yes ☐ No

Patient previously tested in our laboratory? ☐ Yes ☐ No ☐ Unknown

Tests Requested (check all that apply)

- ☐ Immunoglobulin Heavy Chain (*IGH*) Gene Rearrangement by PCR
- ☐ Immunoglobulin Kappa *(IGK)* Gene Rearrangement by PCR
- ☐ T-cell Receptor Gamma (*TCRG)* Gene Rearrangement by PCR
- ☐ T-cell Receptor Beta (*TCRB*) Gene Rearrangement by PCR
- ☐ Quantitative *BCR-ABL1* (p210) by RT-PCR
- ☐ Quantitative *BCR-ABL1* (p190) by RT-PCR
- ☐ Qualitative *PML-RAR alpha* t(15;17) by RT-PCR
- ☐ Hemochromatosis *(HFE)* 2 Mutations
- ☐ Quantitative *JAK2* V617F Mutation
- ☐ Factor V (*F5)* Leiden R506Q mutation
- ☐ Prothrombin (*F2*) G20210A mutation
- ☐ Other (specify) _____

Note: Specimens will <u>not</u> be processed without billing information

☐ **Bill Patient:** _____
Address Phone

☐ **Bill Facility:** _____
Facility Name and Address Patient ID#

☐ **Bill Insurance:** _____
Insurance Company Name and Address

_____
Name of Insured Policy # Group #

_____
Patient Address Telephone # Date of Birth

☐ **Bill Research Account:** _____
Principal Investigator Account #

Revised: May 2025