

COLLAGEN DIAGNOSTIC LABORATORY

LABORATORY TESTING REQUISITION FORM

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www.pathology.washington.edu/clinical/collagen

CLIA # 50D0661462

Peter H. Byers, MD
Laboratory Director

Tel: 206-543-4206
pbymers@u.washington.edu

Melanie Pepin, MS, CGC
Genetic Counselor

Tel: 206-543-5464
mpepin@u.washington.edu

Dru Leistriz, MS
Genetic Counselor

Tel: 206-543-5464
dru2@u.washington.edu

Barbara Kovacich, Office Admin.
Tel: 206-543-0459

kovacich@u.washington.edu
Fax: 206-616-1899

PATIENT INFORMATION

NAME:

DOB: SEX: MALE FEMALE

YOUR PATIENT ID#:

ADDRESS:

CITY: STATE: ZIP:

PHONE:

TEST REQUESTED

(see website for current prices)

COLLAGEN SCREENING:

- from fibroblasts
 from biopsy

MOLECULAR TESTING:

For Osteogenesis Imperfecta:

- COL1A1 and COL1A2 GENOMIC SEQUENCING
 CRTAP GENOMIC SEQUENCING
 LEPRE1 GENOMIC SEQUENCING
 COL1A1 and COL1A2 cDNA (after collagen screen)

For Ehlers-Danlos Syndrome type IV:

- COL3A1 GENOMIC SEQUENCING

For Loeys-Dietz Syndrome:

- TGFBR1 and TGFBR2 GENOMIC SEQUENCING

- TESTING FOR KNOWN MUTATION

Relative: CDL#:

Relationship:

Gene: Mutation:

Provide copy of report if testing done at another laboratory

SAMPLE TYPE:

- Cultured fibroblasts
 Skin biopsy
 Amnio/CVS cells*
- Blood
(min 7cc, Purple top)
 DNA
(min 150µl at ≥200ng/µl)
 Stored cells (CDL)

*Notify CDL in advance of Prenatal Sample

CLINICAL INFORMATION

CLINICAL DIAGNOSIS:

- Osteogenesis Imperfecta

Physical exam:

Medical history:

Family history:

- Ehlers-Danlos Syndrome

Physical exam:

Medical history:

Family history:

- Loeys-Dietz Syndrome

Physical exam:

Medical history:

Family history:

ATTACH CLINIC NOTE

REPORTING RESULTS

REFERRING PHYSICIAN (REQUIRED):

NAME:

NPI #:

PHYSICIAN SPECIALTY:

GENETIC COUNSELOR:

INSTITUTION:

ADDRESS:

CITY: STATE: ZIP:

COUNTRY:

PHONE:

FAX:

EMAIL:

REFERRING LAB:

SEND OUT COORDINATOR:

ADDRESS:

CITY: STATE: ZIP:

COUNTRY:

PHONE:

FAX:

BILLING INFORMATION ON PAGE 2

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BILLING INFORMATION

Please attach a copy of pre-approval for all insurance billing

INSURANCE BILLING

Attach a CLEAR copy of **both sides** of the insurance card.

Cardholder information must also be included.

Name of Cardholder:

Relationship to Insured:

Cardholder DOB:

Social Security #:

ID Number:

Group #:

Insurance Name:

Claims Address:

**Requested laboratory testing
will be initiated only AFTER
accurate billing information
is provided.**

DISCLAIMER: Preauthorization for insurance billing is required. If insurance does not pay for the total cost of testing, we will bill the referring laboratory or physician and the patient.

INSTITUTIONAL BILLING

INSTITUTION:

ADDRESS:

CITY:

STATE:

ZIP:

PHONE:

FAX:

SELF-PAY and INTERNATIONAL SAMPLES:

Check (*payable to UW Physicians*) or Money Order

Credit Card Amount (USD):

Card #: Exp. Date: 3-digit Code:

Card type: Visa MC AmEx Discover

Name of cardholder:

Billing address:

Wire Transfer (recommended for International samples; see website for details)

Amount of Wire Transfer (transfer fee not included): USD

MEDICAID COVERAGE:

For Medicaid billing, please include:

- A pre-authorization letter from Medicaid, with the effective dates of coverage
- Medicaid claims address
- Copy of card
- Letter of necessity from referring physician

**SEND SAMPLES MONDAY THRU THURSDAY
SHIP SAMPLE OVERNIGHT TO:**

Peter H. Byers, MD
Department of Pathology
Rm. D-518, Health Science Bldg.
1959 NE Pacific Street
University of Washington
Seattle, WA 98195-7470