U I D L
UI Diagnostic Laboratories

# MUSCULAR DYSTROPHY MOLECULAR GENETICS REQUISITION
# INTERNATIONAL

UI Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, Iowa 52242
Toll Free: 866-844-2522
Local: 319-384-7212
Client Services Fax: 319-384-7213
Billing Fax: 319-356-0729

**FOR UIDL USE ONLY:** MRN# PATH#

**FOR CLIENT USE ONLY:** Requisition Date Completed by:

| **PART A – PATIENT INFORMATION – *Required*** | | | **PART B – PROVIDER INFORMATION – *Required*** | | |
|---|---|---|---|---|---|
| Patient Last Name: | | | Referring Institution: | | |
| Patient First Name: | | | Street: | | |
| Street: | | | City: | St: | Zip: |
| City: | St: | Zip: | Phone: | Fax: | |
| Phone: | Fax: | | Referring Physician: | | |
| Date of Birth: | Gender: ☐ M ☐ F | | Email: | Phone: | |

**PART C - SPECIMEN INFORMATION** (Complete the appropriate information below or include in an accompanying letter.)
**Ship on Mondays or Tuesdays only, to avoid potential weekend delays. Ship at ambient temperature Priority Overnight.**

**MATERIALS SUBMITTED: ☐ EDTA Whole Blood ☐ DNA ☐ Other (Specify): _____**

**Required ICD-10 codes:** 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

**SPECIMEN COLLECTION DATE:** _____ **SPECIMEN COLLECTION TIME:** _____

**PERTINENT CLINICAL HISTORY AND FINDINGS (please attach pedigree if available):**

**This request to order molecular diagnostic tests from University of Iowa Diagnostic Laboratories (UIDL) certifies to UIDL that the ordering physician has obtained informed consent from the patient as required by applicable state or federal laws for each test ordered and that the ordering physician has authorization from the patient permitting UIDL to report results for each test ordered to the ordering physician.** **Genetic Counseling and Information:** By requesting testing, the ordering physician assumes responsibility for providing the patient with all associated guidance and counseling regarding the test results. Alternatively, patients can be referred to qualified counseling services by contacting client services at ph. (866)844-2522.

**SELECT TEST:** Refer to the UIDL **TEST DIRECTORY** for specimen requirements and CPT Codes at https://www.healthcare.uiowa.edu/path_handbook/rindex.html

| | |
|---|---|
| ☐ **Congenital Muscular Dystrophy type 1C, MDC1C (*FKRP* sequencing)** | ☐ **Limb Girdle Muscular Dystrophy type 2I (*FKRP* sequencing)** |
| ☐ **Congenital Muscular Dystrophy type 1D, MDC1D (*LARGE* sequencing)** | ☐ **Limb Girdle Muscular Dystrophy type 2K (*POMT1* sequencing)** |
| ☐ **Fukuyama Congenital Muscular Dystrophy (*FKTN* sequencing)** | ☐ **Limb Girdle Muscular Dystrophy type 2M (*FKTN* sequencing)** |
| ☐ **Fukuyama Congenital Muscular Dystrophy (Japanese Founder Mutation PCR)** | ☐ **Limb Girdle Muscular Dystrophy type 2N (*POMT2* sequencing)** |
| ☐ ***ISPD* Gene Sequencing** | ☐ **Limb Girdle Muscular Dystrophy type 2O (*POMGnT1* sequencing)** |
| ☐ **Limb Girdle Muscular Dystrophy, autosomal recessive common mutation panel** | ☐ **Muscle-Eye-Brain Disease (*POMGnT1* sequencing)** |
| ☐ **Limb Girdle Muscular Dystrophy, autosomal recessive common mutation panel with *FKRP* sequencing** | ☐ **Myotonic Dystrophy type 1 (DM1)** |
| ☐ **Limb Girdle Muscular Dystrophy type 2B (*Dysferlin* sequencing)** | ☐ **Walker Warburg Syndrome (*POMT1, POMT2, POMGnT1, FKTN, FKRP, ISPD* and *LARGE* sequencing)** |
| ☐ | ☐ |
| ☐ | ☐ |

**PART D – BILLING – REQUIRED** Complete this section for all international samples. UIDL requires international specimens to be accompanied by payment in US dollars. If prepayment is not received, there will be a delay in result reporting. Please call our Billing Department at 00-1-319-353-7958 or email your questions to UIDL@healthcare.uiowa.edu.

**Pre-Payment Required**

☐ **Bank Check Enclosed** (made payable to UI Diagnostic Laboratories)

☐ **Credit Card:** ☐ Visa ☐ MasterCard Card # _____-_____-_____-_____ Expires: ____/____ (MM/YY) Security Code: _____

**Name of Cardholder** (print first name, last name): _____ Phone: _____

**Cardholder Address:** _____

_____

_____

_____

*Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.*

*The purpose of this form is to obtain information necessary for UIDL Pathology Department to perform consultations and/or testing. Failure to properly complete the form may cause delay in the processing of specimens.* *MSO 05-19*