

FSHD1 and FSHD2

INTERNATIONAL REQUISITION

Information submitted must be in English

UIDL USE ONLY: MRN# ()	PATH# -	CLIENT Use Only: Req Date	Completed by: _____
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Name of Carrier: _____	Track Number: _____
Be advised that tracking the delivery time and date of material to the UIDL is the responsibility of the ordering facility.	

PART A – PATIENT INFORMATION – <i>Required</i>	PART B – PROVIDER INFORMATION – <i>Required</i>
Patient Last Name: _____	Referring Institution: _____
Patient First Name: _____	Address: _____
Address: _____	
	Phone: _____ Fax: _____
Phone: _____ Fax: _____	Referring Physician: _____
Date of Birth: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Referring Physician Phone: _____

EMAIL FOR TEST RESULTS (mandatory)

Print email contact _____ Print email address _____

PART C - SPECIMEN INFORMATION (Complete the appropriate information below and attach pertinent clinical history.)

Required Diagnosis: _____

TISSUE SOURCE/SITE: WHOLE BLOOD **DATE OF COLLECTION:** _____

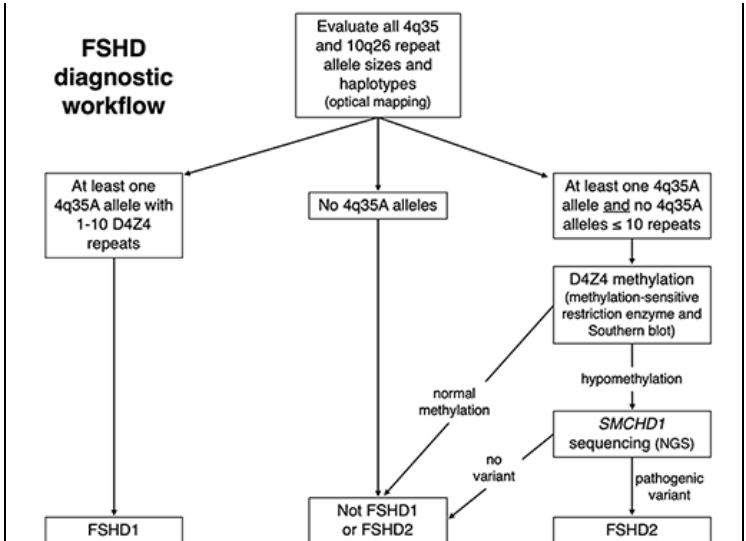
10 mL required volume in pink top tube (EDTA)

Liquid DNA specimens are not acceptable for testing except for methylation studies or SMCHD1 sequencing; minimum DNA concentration 0.25 µg/µl in 50 µl

PART D – FSHD TESTING REQUEST

Full Test Panel (see FSHD diagnostic workflow →) or select the Individual Components being requested:
 Determine Allele Size and Haplotyping
 Methylation SMCHD1 sequence

- By requesting this test, will the ordering physician assume responsibility for providing the patient with associated guidance and genetic counseling regarding the test results (*please circle a response*)? **Yes No**
- Has the patient had prior testing for FSHD? **Yes (provide lab and date):** _____ **No Unknown**
- Does the patient have a 4q35 deletion? **Yes. (provide size of deleted 4q35 EcoRI fragment, if known):** _____ **No Unknown**
- Has the patient undergone 4qA4qB allele testing? **Yes No Unknown**
- Does the patient have one or more 4q35A alleles? **Yes No Unknown**
- Does the patient have a family history of FSHD1 that has been confirmed by molecular genetic testing? **Yes (provide size of deleted 4q35 EcoRI allele, if known):** _____ **No Unknown**
- Does the patient have a family history of FSHD2 that has been confirmed by molecular genetic testing? **Yes (provide SMCHD1 mutation, if known):** _____ **No Unknown**



SHIPPING INSTRUCTIONS: Ship on Mondays, Tuesdays or Wednesdays only, to avoid potential weekend deliveries. Ship at refrigerated temperature Priority Overnight. DO NOT Freeze. **Contact UIDL prior to shipping.**

An [Importer Certification Statement](#) must be completed and submitted with every international referral case.

PART E – REQUIRED BILLING INFORMATION:*

Pre-Pay by Credit Card: Visa MC Discover Card # _____ Expires: _____ Pin # _____

Cardholder (Print last name, first name): _____

Cardholder Email: _____ Cardholder phone#: _____

Pre-Pay by Phone: Call 319-353-7958 between the hours of 8:00 AM-4:30 PM CST M-F Pre-Pay by Email: marysue-otis@uiowa.edu

Date of payment by phone or email _____

Card information given to (insert UIDL state name) _____

The minimum prepayment is \$874 for Determination of Allele Sizes and Haplotyping testing. If the Full Panel is ordered, and all components are deemed to be necessary and are performed, the maximum amount charged will be \$2004.

***If all billing requirements have not been met at the time of specimen arrival, the UIDL will process the submitted specimen to maintain the integrity of the sample for future testing. The Molecular Pathology Laboratory will store specimens. If all billing requirements have not been met after 6 months, the test order itself will be canceled.**

Please refer to the UIDL Test Directory for further details: [FSHD - Detection of Abnormal Alleles with Interpretation \(FSHD1 and FSHD2\)](#) and [Facioscapulohumeral Dystrophy \(FSHD\) Information \(FSHD1 and FSHD2\)](#)