FSHD1 and FSHD2 INTERNATIONAL REQUISITION

Complete for specimens collected outside the United States Optical Mapping | Methylation | NGS

REQUIRED INFORMATION IN RED REFERRING INSTITUTION (CLIENT) INFORMATION				
		INFORMATIO	Ν	
Referring Institution			1	UIDL Client:
Requisition Comple			Date:	
Address Line 1 (street				
	nent, unit, suite, building, floor etc.)			City:
State/Province/Reg	ion:		D	ZIP/Postal Code:
Country:			Phone:	
Referring Physician	:		Physician's Em	nail:
PATIENT INFORMATION				
Last Name:			First Name:	
Gender:	Male	Female	Birth Date:	
Address Line 1 (street				
	nent, unit, suite, building, floor etc.)			City:
State/Province/Reg	ion:			ZIP/Postal Code:
Phone:			Patient's Emai	1:
RESULT DISSEMI	NATION			
Contact:			Email:	
SPECIMEN INFOR	MATION			
Collection Date:			Collection Tir	me (HH:MM):
Specimen Type:	12 mL (10	minimum) whol	e blood	
Collection Medium:	2 pink top	(K2 EDTA) tube	s, 6.0 mL each	
* Nucleic acid (NA) extr				I/nucleic-acid-extracts for UIDL compliance requirements, and
UIDL may accept NA extract				elution buffer, transport instructions, etc.) and approval. ed laboratory or a laboratory meeting equivalent requirements
				institution's CLIA certificate, or certificate recognized by CMS.
TEST REQUEST				
FSHD (FSHD1 & FSHD2) Panel (LAB8104) (Please refer to the below diagnostic workflow)				
FSHD (FSH	D1 & FSHD2) Panel (L	AB8104) (Pleas	e refer to the be	elow diagnostic workflow)
	D1 & FSHD2) Panel (L ore of the following in			
	ore of the following in		anel component	
OR select one or m Allele size and	ore of the following in d haplotyping	dividual FSHD p Methylatio	anel component on	NGS (SMCHD1, LRIF1, DNMT3B)
OR select one or m Allele size and CLINICAL INFOR	ore of the following in d haplotyping MATION (Co	dividual FSHD p Methylatic mplete the fol	anel component on	S:
OR select one or m Allele size and CLINICAL INFORI	ore of the following in d haplotyping	dividual FSHD p Methylatic mplete the fol	anel component on	NGS (SMCHD1, LRIF1, DNMT3B) AND provide pertinent clinical history)
OR select one or m Allele size and CLINICAL INFORI	ore of the following in d haplotyping MATION (Co iician assume responsibili with guidance and geneti	dividual FSHD p Methylatic mplete the fol	anel component on	NGS (SMCHD1, LRIF1, DNMT3B)
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OR select one or m   Allele size and   CLINICAL INFORI   Will the ordering phys   providing the patient of   regarding the test res   Yes   Has the patient had point   Yes   If Yes, provide the follow   Date of testing:   Does the patient have   Yes   If Yes, deleted 4q35 Econ   Has the patient under   Yes   Does the patient have	ore of the following in d haplotyping MATION (Co ician assume responsibil, with guidance and geneti ults? No rior testing for FSHD? No ing Performing lab: a 4q35 deletion? No R1 fragment size, if known: gone 4qA4qB allele testi No e one or more 4q35A alle No	dividual FSHD p Methylation mplete the fol ity for c counseling Unknown unknown ng? Unknown les? Unknown	At least one 4q35A allele with 1-10 D4Z4 repeats FSHD1 SMCHD1-related	S: NGS (SMCHD1, LRIF1, DNMT3B) AND provide pertinent clinical history) FSHD Diagnostic Workflow FSHD Diagnostic Workflow Evaluate all 4q35 and 10q26 repeat allele sizes and haplotypes (optical mapping) At least one 4q35A alleles ≤ 10 repeats D4Z4 methylation (methylation sensitive restriction enzyme and Southern biot) restriction enzyme and SMCHD1, LRIF1, DNMT3B SMCHD1, LRIF1, DNMT3B pathogenic variant in SMCHD1, LRIF1, DNMT3B
OR select one or m   Allele size and   CLINICAL INFOR   Will the ordering physis   providing the patient of   regarding the test ress   Yes   Has the patient had patient of   Yes   If Yes, provide the follow   Date of testing:   Does the patient have   Yes   If Yes, deleted 4q35 Econ   Has the patient under   Yes   Does the patient have   Yes	ore of the following in d haplotyping MATION (Co ician assume responsibilities with guidance and genetic ults? No rior testing for FSHD? No rior testing for FSHD? No rior testing for FSHD? No R1 fragment size, if known: gone 4qA4qB allele testi No e one or more 4q35A alle No e a family history of <b>FSHI</b> plecular genetic testing? No	dividual FSHD p Methylatic mplete the fol ity for c counseling Unknown Unknown ng? Unknown les? Unknown P1 that has	At least one 4q35A allele with 1-10 D4Z4 repeats FSHD1 SMCHD1-related FSHD2 LR/F1-related	S: NGS (SMCHD1, LRIF1, DNMT3B) AND provide pertinent clinical history) FSHD Diagnostic Workflow FSHD Diagnostic Workflow Evaluate all 4q35 and 10q26 repeat allele sizes and haplotypes (optical mapping) At least one 4q35A alleles ≤ 10 repeats D4Z4 methylation D4Z4 methylation restriction erzyme and Southern blot) pathogenic sMCHD1, LRIF1, DNMT3B sequencing (NGS) DNMT3B-related
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FSHD1 and FSHD2 INTERNATIONAL REQUISITION

Complete for specimens collected outside the United States Optical Mapping | Methylation | NGS

**University of Iowa Diagnostic Laboratories** Department of Pathology 200 Hawkins Drive, 5231 RCP Iowa City, IA 52242 Client Services Toll Free: (866) 844-2522 Client Services Local: (319) 384-7212 Client Services Fax: (319) 384-7213

SHIPPING INSTRUCTIONS

Collect specimen as early in the week as possible and ship priority overnight to avoid weekend deliveries.

Maintain frigerated temperatures (**Do NOT Freeze**) and Ship directly to the UIDL:

200 Hawkins Drive, 5231 RCP, Iowa City, IA 52242 Complimentary collection kits are available. If a case requires prepayment, prepayment must be made before placing a collection kit order. To receive a complimentary collection kit, please email <u>UIDLClientServices@healthcare.uiowa.edu</u> NOTE:

An Importer Certification Statement must be completed and submitted with every case.

## **BILLING DIRECTIVE**

Visit the below link to review and ensure compliance with UIDL billing policies and procedures https://uidl.medicine.uiowa.edu/fshd

NOTE: The UIDL's billing policy mandates prepayment for all cases originating outside the US unless otherwise approved.

**Prepayment Required** 

Visit https://uidl.medicine.uiowa.edu/billing/prepayment to make the required prepayment. Prepayment

**Direct Bill** 

Referring Institution (Client)

Requires UIDL approval. Please contact UIDLClientServices@healthcare.uiowa.edu to initiate approval

Please visit the following links for further details related to UIDL FSHD testing: FSHD - Detection of Abnormal Alleles with Interpretation (FSHD1 and FSHD2) Facioscapulohumeral Dystrophy (FSHD) Information (FSHD1 and FSHD2)