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Pathology Resequencing Laboratory
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DICER1 Mutation Analysis Requisition

Patient Information

Patient Name (last, first, mi): _____ Date of Request (mm/dd/yyyy): ___/ ___/ ____

Birthdate (mm/dd/yyyy): ___/ ___/ ____ Sex: ____M ____F Race/Ethnicity: _____

Street Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ E-mail: _____

Sample Information

Sample Type: _____Blood _____Saliva/buccal _____DNA _____ Other (list)_____

Date Collected: ___/ ___/ ____ Time Collected: _____ Person Collecting: _____

Reporting Information

Requesting Physician/Genetic Counselor: _____ Institution: _____

Mailing Address: _____ City, State, Zip: _____

Phone Number: _____ Fax number: _____ Fax results: ___yes ___no

E-mail address: _____ E-mail results: ___yes ___no

Testing Information

DICER1 all exon sequencing _____ Testing for familial mutation ____ Confirmation of research result*_____
*If patient or family member previously tested in research study, please call laboratory 202-476-2051

Reason for testing (diagnosis):

O Lung cyst O Pleuropulmonary Blastoma O Rhabdomyosarcoma O Cystic Nephroma O Ovarian Stromal Tumor
O Relative of patient O Asymptomatic/presymptomatic testing O Other: _____

ICD9 Code(s): _____

Please include relevant clinical information/pedigree information along with this requisition form.

Ordering Checklist:

O Informed consent
O Clinical findings/pedigree included if available
O Tubes labeled with patient name, birthdate, date and time of collection

Physician Signature: _____