



**Children's**  
*National Medical Center*  
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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):**

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

ICD9 Code(s): \_\_\_\_\_

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

### **Ordering Checklist:**

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

**Physician Signature:** \_\_\_\_\_