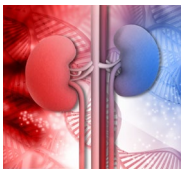


KIDNEYSEQ™ VERSION 4 – 312 GENES

IOWA INSTITUTE OF HUMAN GENETICS

CLINICAL TEST REQUISITION FORM

CLIA ID 16D2053873 | CAP ID: 8864771

431 Newton Road, 140 EMRB
Iowa City, IA 52242-1078
Phone: 319-335-3688 Fax: 319-335-3484
Email: iihg@uiowa.edu
www.medicine.uiowa.edu/humangenetics/

Patient Information	Specimen Information
- Place patient ID sticker here - -OR- Name: _____ _____ Last First DOB: ____ /____ / _____ Sex: ☐Male ☐Female MM/DD/YYYY	Specimen Collection Date: ____ /____ / _____ MM/DD/ YYYY Specimen Type: ☐ ~6mL EDTA whole blood ☐~3mL EDTA whole blood (pediatric) ☐10µg DNA @110ng/ml (minimum) CLIA ID:_____ *DNA must be extracted in a CLIA certified laboratory. For labs outside of the USA, equivalent requirements apply. MRN: Accession #:

Clinical Indication for Testing (required)

1. What is your working clinical diagnosis?
2. What are the salient clinical features?
3. What are the relevant laboratory data?
4. Is there a family history? ☐Yes ☐No (If yes, provide details and attach pedigree)

***Providing more detailed and relevant clinical records will help in the interpretation of genetic findings. Please include a phone number for the treating clinician as the IIHG may need to discuss findings or obtain additional clinical information.

Clinical information can be emailed to iihg@uiowa.edu or faxed to 319-335-3484

Patient Race		Patient Ethnic Group/Identification	
☐Asian ☐African / African American ☐Caucasian ☐Native American (American Indian or Alaska Native) ☐Native Hawaiian/Pacific Islander	☐Unknown/Unspecified ☐Multiracial/Two or More Races ☐Declined ☐Other_____	☐Non-Hispanic ☐Hispanic or Latino ☐Jewish – Sephardic ☐Jewish – Ashkenazi ☐Eastern Indian ☐Mediterranean	☐Unknown ☐Declined

Billing Information (required prior to testing)

Institutional billing ONLY at this time. The IIHG does not do direct insurance billing or direct patient billing at this time.

Institution Name:	Billing Contact:
Institution Code:	Billing Contact Email:
Street Address:	Phone:
City: State: Zip:	Fax:

Reporting Information (fax# required to send results)		Additional Report Recipient (fax# required to send results)	
Health Care Provider:		Health Care Provider:	
NPI:		NPI:	
Institution:		Institution:	
Department		Department	
Email:		Email:	
Phone:	Fax:	Phone:	Fax:

Test Menu – select one or more options

KidneySeq™:

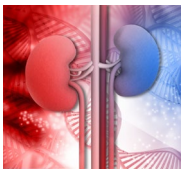
- ☐Comprehensive testing (312 genes)
- ☐CAKUT (56 genes)
- ☐Ciliopathies/tubulointerstitial diseases (85 genes)
- ☐Disorders of tubular ion transport (72 genes)
- ☐Glomerulopathies (78 genes)
- ☐Nephrolithiasis/ nephrocalcinosis (35 genes)

Single gene tests:

- ☐*APOL1* test: G1 and G2 alleles
- ☐Familial testing (segregation analysis)
  - Patient information on page 1 should match the accompanying sample
  - Family member information on page 2 should identify other members being tested, including the index patient.

CPT codes on page 2

IIHG ID:
(Office use only)



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Phone: 319-335-3688 Fax: 319-335-3484
Email: iihg@uiowa.edu
www.medicine.uiowa.edu/humangenetics/

Patient Name:_____ Last First M	DOB: ____ /____ / _____ MM / DD / YYYY	IIHG ID: (Office use only)

Familial Testing (segregation analysis)
(testing to determine if other family members carry the same genetic variant identified in the index person)

Family member #1	**Family member #2**
Last Name:	Last Name:
First Name:	First Name:
Relationship to patient listed on page 1:	Relationship to patient listed on page 1:
DOB: ____ / ____ / _____ MM / DD / YYYY	DOB: ____ / ____ / _____ MM / DD / YYYY
☐Asymptomatic ☐Symptomatic	☐Asymptomatic ☐Symptomatic

If more than two persons are to be tested, please include a pedigree. For assistance in constructing a pedigree please see https://medicine.uiowa.edu/humangenetics/resources/how-draw-pedigree

Sample Requirements

- Samples **must** be labeled with the patient's full name and date of birth. Samples received without both pieces of information cannot be processed and will be discarded.
- Biological parent or other relative samples **must** be labeled with that person's full name and date of birth, NOT the index patient's information. Samples received without both pieces of information cannot be processed and will be discarded.
- 6 mL whole blood in lavender **EDTA tube** (3 mL pediatric minimum).
  OR
  10µg DNA (A260/A280 1.8-2) resuspended in 0.1mM EDTA (10mM Tris HCl, 0.1mM EDTA, pH 8, Teknova Cat #T0220)
  *DNA must be extracted by a CLIA certified laboratory. For laboratories outside of the USA, equivalent requirements apply. Please include a copy of the accreditation standards and certificate of accreditation.

Shipping Requirements

- Samples may be shipped at ambient temperature or with an ice pack. DO NOT freeze sample.
- If the sample is collected on a Friday, refrigerate the sample over the weekend for shipping the following week.
- Samples should be shipped for next day delivery, Tuesday-Friday. Samples are not received on weekends or US holidays.
- Please contact us at iihg@uiowa.edu or 319-335-3688 with any questions or concerns.
- Ship overnight to:
  Iowa Institute of Human Genetics
  University of Iowa
  431 Newton Road, 140 EMRB
  Iowa City, IA 52242
  Phone: 319-335-3688

CPT Codes:

- KidneySeq™
  - Comprehensive testing: 81404, 81405, 81406, 81407, 81408, 81479
  - CAKUT: 81405, 81406, 81407, 81479
  - Ciliopathies/tubulointerstitial diseases: 81404, 81405, 81406, 81407, 81408, 81479
  - Disorders of tubular ion transport: 81404, 81405, 81406, 81407, 81479
  - Glomerular diseases: 81404, 81405, 81406, 81407, 81408, 81479
  - Nephrolithiasis/nephrocalcinosis: 81404, 81405, 81406, 81407, 81479
- *APOL1* test: 81479
- Familial Testing: 81479