ACCU REFERENCE MEDICAL LAB® CAP ACCREDITED
1901 EAST LINDEN AVE.
SUITE 4, LINDEN, NJ 07036
T: (908) 474-1004
F: (908) 474-0032

CARRIER SCREENING

PROVIDER INFORMATION

PATIENT'S INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE

RACE / ETHNICITY ☐ AMERICAN INDIAN/ ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ HISPANIC OR LATINO ☐ HAWAIIAN/PACIFIC ISLANDER ☐ WHITE

GENDER	DOB (MM/DD/YY)	MOBILE PHONE	EMAIL
☐ M ☐ F ☐ OTHER			

ADDRESS	APT #	CITY	STATE	ZIP

TESTS

☐ **CARR** CARRIER SCREENING TESTS
- ☐ **CFXZ** CYSTIC FIBROSIS, 60 MUTATIONS
- ☐ **SMA** SPINAL MUSCULAR ATROPHY
- ☐ **FX** FRAGILE X SYNDROME

Specimen & Handling Requirements
- 1 lavender tube containing 3-4 mL of whole blood **EXCLUSIVE** for genetic testing.
- Transport EDTA whole blood at Room temperature (20° to 25°C) within 48 hours. Specimens are stable for up to 30 days refrigerated (2° to 8°C).

REASON FOR TESTING

☐ Clinically normal pregnant woman ☐ Father has family history of the condition ☐ Father is a carrier of the condition
☐ Family history of the condition ☐ Other _____

FAMILY HISTORY

Are other relatives known to be affected? ☐ Yes ☐ No If Yes, indicate relationship to patient: _____
Are other relatives known to be carriers? ☐ Yes ☐ No If Yes, indicate relationship to patient: _____
Have other relatives had molecular genetic testing? ☐ Yes ☐ No If Yes, complete the information below:

Gene: _____

Name of individual tested *(Last, First, Middle)*: _____
Birth date of individual tested *(mm-dd-yyyy)*: _____
Mutations: _____
Laboratory at which testing was performed: _____

ICD-10 / DIAGNOSES

Please order only if medically necessary and appropriate for individual patients.

PHYSICIAN VISIT NOTES

CHECK LIST

SUBMITTED DOCUMENTS	ON THE REQUISITION FORM	SPECIMEN
☐ A copy of the Patient ID	☐ Detailed patient's information	☐ One whole blood EDTA (Lavender top) tube
☐ A copy of the Patient insurance card (front and back)	☐ ICD-10 codes	
☐ Signed copies of the Informed consent	☐ Patient's medical record	
☐ A signed copy of the Self-pay agreement		

VERSION 1.2 REVISED 11/03/23

PHYSICIAN'S SIGNATURE _____ **DATE** _____