Please Submit this Requisition with each Specimen

Department of Genetics
Metabolic Disease Laboratory
Lysosomal Storage Diseases Service

Patient and Specimen Information

Date Specimen Collected_____

Type Specimen_____

PLEASE COMPLETE ALL QUESTIONS FOR WHICH INFORMATION IS AVAILABLE. PLEASE CHECK WITH METABOLIC DISEASE LABORATORY BEFORE SUBMITTING ANY SAMPLES.

TO CONTACT THE LABORATORY, CALL (205) 934-6370.

DISEASE(S) QUESTIONED:_____

TESTS REQUESTED:_____

NAME OF PATIENT:_____ DOB:_____

REFERRING PHYSICIAN:_____ PHONE:_____

OFFICE ADDRESS OF PHYSICIAN:_____
CITY, STATE, ZIP:_____

INFORMATION ABOUT PATIENT:
ALL INFORMATION REGARDING YOUR PATIENT WILL BE KEPT STRICTLY CONFIDENTIAL.

FAMILY HISTORY OF GENETIC DISORDER (ATTACH PEDIGREE IF POSSIBLE)
_____

_____

_____

BRIEF MEDICAL HISTORY (OR INCLUDE CLINICAL SUMMARY)
_____

_____

_____

IS PATIENT TAKING MEDICATION?_____

CLINICAL INFORMATION:

HEAD
CIRCUMFERENCE_____HEIGHT_____

FACIAL FEATURES:
DYSMORPHIC_____

OTHER_____

EYES: BLINDNESS_____CORNEAL CLOUDING_____

OPTIC ATROPHY_____CHERRY-RED MACULAE_____

SKIN:
TEXTURE_____ RASH_____

VISCEROMEGALY:
LIVER_____SPLEEN_____

SKELETAL :
HAS PATIENT HAD X-RAYS_____

X-RAYS: SKULL_____VERTEBRAE_____

CAT SCAN/MRI_____

HERNIAS_____GIBBUS_____

NEUROLOGICAL EXAMINATION:
DEVELOPMENT:_____

RETARDED_____BEHAVIOR DISORDER_____

WALKS_____TALKS_____TOILET TRAINED_____

MOTOR SYSTEMS:
STARTLES EASILY_____TREMORS_____

SEIZURES _____

LABORATORY RESULTS:
URINE: BERRY SPOT TEST_____

AMINO ACIDS_____

ORGANIC ACIDS_____

METABOLIC SCREEN_____

Billing Information

The Metabolic Disease Laboratory **does not Bill the patient or the patient's Insurance Co.**
The Institution, Laboratory or Office submitting the specimen(s) is Billed.

or

A check for total amount of service may be submitted with the specimen.

Referring Institution or Laboratory

Name_____

Address_____

City, State, Zip_____

Contact Phone_____

Fax Number_____

Services Available

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