



BIOCHEMICAL GENETICS/CYSTINE LAB
 PEDIATRICS, CTFB BLDG., RM. 213
 UNIVERSITY OF CALIFORNIA, SAN DIEGO
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 AND W.L. NYHAN, M.D., Ph.D.

CLIA ID: 05D0643075 TAX ID: 33-0833316 NPI ID: 1932264413

PATIENT NAME: _____

DATE OF BIRTH: _____ SEX: M F

PATIENT ID #: _____

INPATIENT

OUTPATIENT

UCSD LAB USE ONLY	LOC CODE: _____	UCSD SAMPLE #: _____	DATE/TIME RECEIVED: _____
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1. PHYSICIAN INFORMATION REQUIRED FOR BILLING PURPOSES

REQUESTING PHYSICIAN: _____	STATE LICENSE #: _____	UPIN #: _____
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RESULTS ADDRESS				BILLING ADDRESS (WE DO NOT BILL PATIENTS OR INSURANCE)			
NAME: _____				NAME: _____			
HOSPITAL: _____				HOSPITAL: _____			
STREET: _____	CITY: _____	STATE: _____	ZIP: _____	STREET: _____	CITY: _____	STATE: _____	ZIP: _____
PHONE: _____	FAX: _____			PHONE: _____	FAX: _____		

2. SAMPLE INFORMATION (ONLY ONE SPECIMEN TYPE PER REQUISITION, PLEASE)

COLLECTION DATE: _____	COLLECTION TIME: _____ AM PM	SPECIMEN KEY: U - URINE M - MUSCLE P - PLASMA BS - BLOODSPOT C - CSF F - FIBROBLAST BX - SKIN BIOPSY B - WHOLE BLOOD WBC - WHITE BLOOD CELLS
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3. TEST/SERVICE SELECTION

MARK THE TEST OR SERVICE YOU ARE REQUESTING AND **CIRCLE** THE SPECIMEN TYPE (SEE SPECIMEN KEY AT RIGHT). PROVIDE ADDITIONAL REQUIRED INFORMATION AS REQUESTED AND CLINICAL HISTORY BELOW.

ORGANIC ACIDS	CIRCLE SPECIMEN TYPE	AMINO ACIDS	CIRCLE SPECIMEN TYPE
<input type="checkbox"/> QUANTITATIVE ORGANIC ACIDS	U P C	<input type="checkbox"/> QUANTITATIVE AMINO ACIDS	U P C
<input type="checkbox"/> METHYLMALONIC ACID	U P	<input type="checkbox"/> HOMOCYST(E)INE, TOTAL	P
<input type="checkbox"/> N-ACETYLASPARTIC ACID	U	<input type="checkbox"/> PKU PANEL (PHE/TYR)	BS
<input type="checkbox"/> OROTIC ACID	U	MISCELLANEOUS	
<input type="checkbox"/> SUCCINYLACETONE	U	<input type="checkbox"/> ACYLCARNITINE PROFILE	P
CYSTINOSIS TESTING		<input type="checkbox"/> CARBOXYLASES ENZYME ASSAY (PYRUVATE, PROPIONYL CoA, 3-METHYLCROTONYL CoA)	B F
<input type="checkbox"/> CYSTINOSIS DIAGNOSIS (CYSTINE ASSAY)	B WBC	CLINICAL HISTORY NEEDED FOR INTERPRETATION (SEE SECTION 4)	
<input type="checkbox"/> CYSTINOSIS MONITORING (CYSTINE ASSAY) SELECT MEDICATION PATIENT IS TAKING <input type="checkbox"/> CYSTAGON <input type="checkbox"/> PROCYSBI	B WBC	<input type="checkbox"/> CARNITINE, TOTAL, FREE	U P M
<i>(see www.cystinosiscentral.org for sample requirements, shipping and handling)</i>		<input type="checkbox"/> HGPRT ENZYME ASSAY (LESCH-NYHAN DISEASE)	BS
		<input type="checkbox"/> SUCCINYLPURINE SCREEN	U

DATE, TIME OF LAST 2 DOSES OF MEDICATION (REQUIRED FOR ALL CYSTINOSIS TESTING)	BIOPSY/CELL CULTURE
DATE: _____ TIME: _____ AM PM	CIRCLE SPECIMEN TYPE <input type="checkbox"/> ESTABLISH FIBROBLAST CULTURE BX <input type="checkbox"/> FIBROBLAST CONTINUED CULTURE F <input type="checkbox"/> FIBROBLAST STORAGE F <input type="checkbox"/> FIBROBLAST RECULTURED FROM STORAGE F
DATE: _____ TIME: _____ AM PM	

4. PROVIDE CLINICAL HISTORY TO ASSIST IN INTERPRETATION

CIRCLE THOSE THAT APPLY	DEVELOPMENTAL DELAY	HIGH LACTATE	KETONURIA	PKU
ABNORMAL NEWBORN SCREENING RESULTS	DIABETES	HPRT; LESCH-NYHAN	KIDNEY DISEASE	SEIZURES
ACIDOSIS	FATTY ACID OXIDATION DISORDER	HYPERAMMONEMIA	MITOCHONRIAL METABOLISM DISORDER	STROKES
CARNITINE PALMITOYL TRANSFERASE	FAILURE TO THRIVE	HYPEROXALURIA	METABOLIC DISORDER	UREA CYCLE DISORDER
COMA	HEARING LOSS	HYPERGLYCEMIA	LEIGH DISEASE	VOMITING
	HEART DISEASE/CARDIOMYOPATHY	HYPOTONIA	MSUD	

COMMENTS OR SPECIAL INSTRUCTIONS:
