UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

Translational Genomics Laboratory
655 W. Baltimore St. BRB 7-037
Baltimore, MD 21201
410 706 3339
CAP# 8017554
CLIA# 21D2027356

Individual Authorized to Complete Test Requisition	Report to Name (ordering physician) **Please Print**			Additional Report Recipient
Authorized Person's Signature	Date	Phone #	Fax #	Email

Test Requested:

- □ Confirmation of Research Finding (CRF)
- □ *CYP2C19* Genotyping
- □ *CYP2C19* Sequencing
- □ Cytogenomic Microarray
- □ *FLT3* ITD & TKD Analysis
- □ *IDH1* R132 & *IDH2* R140 & R172 Sequencing
- □ Site-Specific Familial Variant Analysis (SFVA)
- □ Site-Specific Variant Analysis: KCNQ1 c.671C>T p.(Thr224Met)
- □ Myeloid Malignancy Mutation Panel
- □ Solid Tumor Comprehensive Panel

Report to Address: Results *will be sent to this address*

Indication for Testing/Clinical Details/Comments:

ICD-10 codes _____ _____ _____ _____

Patient Name or Sample ID	Gender	Date of Birth	MRN	Date/Time Collected	Sample Type	TGL Sample Number

Shaded Area for Translational Genomics Laboratory Use Only

Date & Time Received: _____ Package Integrity: Acceptable? ☐ Yes ☐ No

Received/Numbered By: _____ Sample Condition: Acceptable? ☐ Yes ☐ No