



# IBR Specialty Clinical Laboratories

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## FRAGILE X MOLECULAR ANALYSIS

PATIENT NAME (Last, First, M.I.)		Date of birth	Sex M [ ] F [ ]
Street address		Phone #	
City	State	Zip	
ETHNIC BACKGROUND: Caucasian [ ] Afro American [ ] Hispanic [ ] Asian [ ] American Indian [ ] Other(specify) [ ] _____			

The purpose of this test is to examine a region of DNA within the fragile X gene. The test consists of DNA analysis of the CGG repeat associated with fragile X syndrome, a common cause of inherited mental retardation. A positive test indicates that the individual is a carrier or is affected by fragile X. The test is ~99% accurate, but rare diagnostic errors may occur. No tests other than those authorized or needed to confirm a result shall be performed on the sample and it will be discarded 60 days after receipt unless you give permission below to use any extra sample for research. You may seek genetic counseling if you wish.

**I understand the above and give consent for diagnostic testing only:**

\_\_\_\_\_  
 Name (printed and signature) of Subject or Parent or Guardian      Date      Witness (printed and signature)

I give permission for any extra sample to be saved and used for future research related to developmental disabilities. I understand that samples will be coded to protect my confidentiality. I authorize the laboratory to store such samples for an indefinite period of time. I may, however, withdraw my permission without penalty, at which time the sample will be destroyed.

**I understand the above and give consent for diagnostic testing and to use the remaining sample for research:**

\_\_\_\_\_  
 Name (printed and signature) of Subject or Parent or Guardian      Date      Witness (printed and signature)

**NOTE:** The information on this referral form is confidential and is under the protection of the HIPAA Privacy Rule of 1996. If it has arrived at the wrong address, please destroy this form and notify us as soon as possible. Thank you.

PATIENT INFORMATION	
Name of Insured _____	Insurance Company _____
Relationship to Patient (circle) : Self Spouse Child Other [ ] _____	ID# _____
<i>Attach a copy of both sides of patient's insurance card</i>	

REASON FOR TEST	
Mental Impairment: Yes ___ No ___ In a Family member: Yes ___ No ___ If yes, name(s) _____	Positive test for fragile X: Yes ___ No ___ Name(s) _____ Lab _____ If yes: Intermediate _____ Premutation _____ Full Mutation _____
Is a pregnancy involved? _____ LMP _____ Other reason for the test? _____	

REFERRAL INFORMATION	
Physician Name (printed and signature)	Address
Telephone #      FAX #	City, State, Zip
License #      UPIN #	
Genetic Counselor	Address
Telephone #      FAX #	City, State, Zip

SPECIMEN TYPE	
[ ] Blood: 10 ml, lavender tube    [ ] Amniotic fluid: 10 ml    [ ] CVS: 5-10mg	Collection date :
[ ] Cultured CV    [ ] Cultured AF    [ ] No. flask(s)	US date:      Gest. age by US date:

DIAGNOSIS					
Infantile Autism	299.0	Moderate mental retardation	318.0	Pregnancy at risk	655.23
Mild mental retardation	317	Severe mental retardation	318.1	Family history of mental retardation	V18.4
Developmental delay	783.42	Profound mental retardation	318.2	Family member carrier of genetic disease	V18.9