



# 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 intellectual disabilities. 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 INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Insurance Company \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_ ID # \_\_\_\_\_  
 Self Spouse Child Other \_\_\_\_\_ *Attach a copy of both sides of patient's insurance card*

### REASON FOR TEST

Mental Impairment Yes No Positive test for fragile X Yes No  
 In a Family member Yes No Name(s) \_\_\_\_\_  
 If yes, 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) \_\_\_\_\_  
 Telephone # \_\_\_\_\_ FAX # \_\_\_\_\_ Address \_\_\_\_\_  
 License # \_\_\_\_\_ UPIN # \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 Genetic Counselor \_\_\_\_\_  
 Telephone # \_\_\_\_\_ Address \_\_\_\_\_  
 FAX # \_\_\_\_\_ City, State, Zip \_\_\_\_\_

### SPECIMEN TYPE

Blood: 10 ml lavender tube Amniotic fluid: 10 ml CVS 5-10 mg Collection date: \_\_\_\_\_  
 Cultured CV Cultured AF No. flasks(s) \_\_\_\_\_ US date: \_\_\_\_\_ Gest. age by US date: \_\_\_\_\_

DIAGNOSIS (check all that apply)				Genetic carrier of other disease	Z14.8
Autism Spectrum Disorder	F84.8	Severe intellectual disabilities	F72	Maternal care for (suspected) hereditary disease in fetus, not applicable or unspecified	O35.2XX0
Mild intellectual disabilities	F70	Profound intellectual disabilities	F73	Family history of intellectual disabilities	Z81.0
Moderate intellectual disabilities	F71	Delayed milestone in childhood	R62.0	Family history of carrier of genetic disease	Z84.81