



IBR Specialty Clinical Laboratories

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ULTRASTRUCTURE

PLEASE TYPE OR PRINT (WRITE FIRMLY) - OMRDD Facilities: Please Use ID Card In Box Below

PATIENT INFORMATION		First		M.I.	D.O.B.	SEX	DIAGNOSIS: ICD-9-CM
Name	Last					M F	
Address					Street		
City					State		
Zip					FACILITY CONSECUTIVE #		
PERSON RESPONSIBLE FOR BILL (OUTPATIENTS ONLY)					COMPLETED INSURANCE FORM OR COPY OF MEDICAID CARD REQUIRED		
Name		Last		First	Telephone ()		
Address				City	State	Zip	
PHYSICIAN INFORMATION		MMIS #	State	Number	Facility		
Name (Print)		or Lic. #					
Address				City	State	Zip	
Telephone ()			PHYSICIAN'S SIGNATURE		Date / /		

ULTRASTRUCTURE - ELECTRON MICROSCOPY

DATE OF BIOPSY:

____/____/____

- | | | | |
|-------------------------------|------------|-------------------------------|-----------------|
| 2300 <input type="checkbox"/> | SKIN | 2306 <input type="checkbox"/> | KIDNEY |
| 2303 <input type="checkbox"/> | BUFFY COAT | 2307 <input type="checkbox"/> | BRAIN |
| 2304 <input type="checkbox"/> | NERVE | 2308 <input type="checkbox"/> | TUMOR |
| 2305 <input type="checkbox"/> | MUSCLE | <input type="checkbox"/> | OTHER - SOURCE: |

Specimens Should Be Shipped MONDAYS - THURSDAYS ONLY !

PERTINENT PATIENT HISTORY: INCLUDE A CLINICAL SUMMARY

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.

--- For Lab Use Only ---

Accession No.	Date	Entered By:	Reviewed By:
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Description, Principle, and Purpose of Test: These tests rely upon ultrastructural (electron microscopy, or EM) studies of whole blood, skin (biopsy), nerve, and conjunctiva for the detection of lysosomal storage disease caused by different genetic disorders, all of which involve mental retardation or other abnormalities. These studies are a valuable diagnostic tool for patients whose enzymatic defects are poorly understood and in cases in which the disease has not been demonstrated by biochemical or molecular genetic means, or in which it has been demonstrated but the usual clinical presentation made the diagnosis difficult. Because the diseases involved are genetic, I understand that the results will have implications for other members of my family. The patient and/or guardian may want to obtain genetic counseling prior to consenting for any of these tests.

Result Interpretation and Test Limitations: The test result may be negative because the patient doesn't have the disease in question. The test result may be positive because the patient does have the disorder in question. The laboratory may request a repeat specimen to confirm positive results. A repeat specimen may also be requested because the original sample may have been inadequate after processing, or may not have been properly maintained after collection (e.g., exposure to temperature extremes). While results obtained are usually accurate, infrequent errors (false positive or false negative types) may occur. It is understood that test results will be sent only to the physician or facility that ordered the test, without further written consent. Law requires that results be reported to a physician only.

Specimen Retention: The specimens tested will remain in the laboratory for no longer than 60 days and only for the purpose of completing the specific test requested, unless you authorize de-identification of the specimen for future research studies that have been approved by an Institutional Review Board.

I understand the above, and I authorize that my specimen be used for diagnostic genetic testing only:

Name (printed and signature) of
Subject or Parent or Guardian

Date

Witness (printed and signature)

I give my permission for any extra sample to be saved for research. I understand that names and other identifiers will be removed from the sample to protect my confidentiality. I authorize the laboratory to keep such samples for an indefinite period of time.

I understand the above, and I give consent for diagnostic testing and for use of the remaining sample for research:

Name (printed and signature) of
Subject or Parent or Guardian

Date

Witness (printed and signature)

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