Children's Hospital of Philadelphia®
Palmieri Laboratory for Metabolic & Advanced Diagnostics

The Palmieri Laboratory for Metabolic & Advanced Diagnostics
Room 5NW55 Main
3401 Civic Center Blvd, Philadelphia, PA 19104
Phone: 215-590-3394 Fax: 215-590-1998
email: MetabolicLab@chop.edu
https://www.chop.edu/centers-programs/metabolic-and-advanced-diagnostics

Patient Information

Last Name: _____

First Name: _____

Patient ID / Med Rec #: _____

DOB: _____

Gender: ☐ Male ☐ Female ☐ Unknown

Physician Name: _____

Physician Phone: _____

Physician Signature: _____

Reference Laboratory Billing Information

WE DO NOT BILL PATIENTS OR THEIR INSURANCE COMPANIES

Institution: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Name: _____

Phone: _____ Fax: _____

By using and sending this Requisition Form to CHOP Outreach Lab for laboratory testing, you, the sender, acknowledge and agree that you have read and agree to the CHOP Terms and Conditions posted at www.chop.edu/labs and agree to pay CHOP the rates in CHOP's fee schedule in effect on the date the specimen in received.

Required Information for New York State Patients

One of these must be checked or testing will not be performed

☐ Informed Consent for Genetic Testing is on file in Physician's Office

☐ Physician has initialed that consent for Genetic Testing was discussed with Patient.

Initials: _____ Date: _____

Required for all NJ & PA Newborn Screening Patients

Please check the appropriate State Screening Program Information

☐ NJ NBS Program ☐ Initial Testing ☐ Continued Monitoring

☐ PA NBS Program ☐ Initial Testing ☐ Continued Monitoring

Clinical Information (Required for NBS Patients / Suggested for All Others

1. **Presumptive Diagnosis:** _____
2. **ICD-10 Code:** _____
3. **Other Abnormal Findings:** _____
4. **Medication:** _____

Specimen Information (only one Sample Type per requisition)

Type: ☐ Blood (B) ☐ Plasma (P) ☐ Serum (S) ☐ Protein Free Blood (PB) ☐ Protein Free CSF (PC) ☐ CSF (C)

☐ Urine (U) Random Timed ☐ Duodenal Biopsy (DB) ☐ Washed Red Blood Cells (wRBC) ☐ Cultured Fibroblasts (F)

Collection Date: _____ **Collection Time(s):** _____ **Your Lab Number:** _____

Testing Requested

Amino Acid Quantitation	☐ P	☐ S	☐ U	☐ C
Acylcarnitine Profile	☐ P	☐ S		
Carnitine (Total & Free)	☐ P	☐ S	☐ U	
Methylmalonic Acid Quantitation	☐ P	☐ S		
Organic Acid Analysis	☐ U	☐ C		
Orotic Acid Quantitation	☐ U			
O-glycan	☐ P	☐ S		
N-glycan	☐ P	☐ S		
Carbohydrate Deficient Transferrin	☐ P	☐ S		
Essential Fatty Acid Profile	☐ P	☐ S		
Myoinositol Analysis	☐ P	☐ S	☐ U	☐ C

Testing Requested

Gal1PO$_4$ Uridyltransferase (GALT) Activity	☐ B	☐ wRBC
Gal1PO$_4$ Analysis	☐ B	☐ wRBC
Galactokinase Enzyme Activity	☐ B	☐ wRBC
Epimerase Enzyme Activity	☐ B	☐ wRBC
Galactitol Anlysis	☐ U	
Lysosomal Enzyme Panel	☐ B	
Disaccharidase Analysis	☐ **DB**	

***Note: Blood samples for Galactosemia and Lysosomal Enzyme testing should be shipped Monday through Thursday and within 24 hours of collection. For all other samples, see test description list for specific handling instructions.