

---

## PATIENT INFORMATION SHEET

**Note:** To satisfy CLIA requirements, and for our laboratory to provide you with test results, all parts of the upper portion of this form must be filled out. We would appreciate all parts in the lower portion to be also filled out if the information is available.

Affix Patient ID sticker here  
if available

Information on sticker does not have  
to be repeated below

---

Patient's name: \_\_\_\_\_ NIH ID: \_\_\_\_\_  
Family Name, First Name, Middle Name (for NIH patients only)

Birth date: \_\_\_\_\_ Gender: \_\_\_\_\_ Date/time blood drawn: \_\_\_\_\_  
mth/day/yr m/f mth/day/yr - hr

Ordering Physician's Name (print legibly): \_\_\_\_\_

Physician's phone no: \_\_\_\_\_ FAX no: \_\_\_\_\_

Physician's address: \_\_\_\_\_  
\_\_\_\_\_

Tests requested (check each test requested):

DNA-Based Mutation Screening of the Menkes/Occipital Horn Syndrome Gene

**Specimen Requirements:** 3 to 7 ml of whole blood in a lavender top tube. Please send at room temperature. Mailing time should not exceed 7 days from date of blood draw and delivery to NIH should be Monday thru Friday. (Weekend/Holiday specimen arrivals require special arrangement with lab director.) Please send to:

SG Kaler, MD MPH  
National Institute of Child Health and Human Development  
National Institutes of Health  
Building 10; Room 5-2571  
10 Center Drive MSC 1832  
Bethesda, Maryland 20892-1832

Reason for Test: \_\_\_\_\_

---

Information below is not essential for report to be returned to ordering physician

Please include any pertinent history and clinical data, including birth history, family history, age at presentation, results of any specialized tests such as neuroimaging, EEG, and serum copper & ceruloplasmin levels.

---

---

---

---

---