



Biotinidase Deficiency Confirmatory Testing Request Form

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CAP # 2379301 CLIA # 05D1038598 CA State License # CLF332530

CS0800

Patient Information

Patient Name _____
Last First

AKA (if applicable) _____

DOB ____ / ____ / ____ SEX ____ LPCH MRN (if applicable) _____

NBS Accession # ____ - ____ - ____ / ____ - ____ - ____

Metabolic Center (copy of results to:)

Institution _____
 Physician Name _____
 Address _____

 City, State, Zip _____
 Phone _____
 Fax _____

Primary Provider

Physician Name _____

Test and Specimen Information

Specimen: ____ Serum ____ Plasma

Collected: Date _____ Time _____
 Collected by _____

Test ordered: (NBBTD) BIOTINIDASE, F/U Newborn Screen

Specimen requirements:

- Collect 2-3cc whole blood
 - Serum (Gold- or Red-Top)
 - Plasma (Mint- or Green-Top)
- Spin and freeze within 30 minutes of collection
- Send frozen on dry ice

Additional Information

In addition to collecting blood from the patient, we recommend that blood also be collected from the parents and included in the shipment at the same time if possible. This aids in the interpretation of some cases of variant biotinidase deficiency. Please check the appropriate box:

No specimens from the parents were collected

Specimen from one biological parent is included: ____ Mother ____ Father

Specimens from both biological parents are included