

TO BE FILLED IN BY CORIELL CELL REPOSITORIES

Repository Number \_\_\_\_\_

Date Received \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Year

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## NIGMS Human Genetic Cell Repository

### SUBMISSION FORM

Please **check** or **complete** all applicable items.

Submitting Investigator \_\_\_\_\_

Diagnosis: \_\_\_\_\_

OMIM Number: (if available) \_\_\_\_\_

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### SUBJECT INFORMATION:

Laboratory I.D.: \_\_\_\_\_ (Do Not use  
subject's name)

AGE AT TIME OF SAMPLING:  
\_\_\_\_ Years      \_\_\_\_ Months      \_\_\_\_ Weeks      \_\_\_\_ Days      \_\_\_\_ Newborn  
If fetal tissue \_\_\_\_\_ Fetal Weeks Gestation

PHENOTYPIC SEX:  
\_\_\_\_ Male      \_\_\_\_ Female      \_\_\_\_ Ambiguous

ETHNIC ORIGIN: (optional) \_\_\_\_\_

CLINICAL PHENOTYPE:  
\_\_\_\_ Clinically Affected      \_\_\_\_ Clinically Normal      \_\_\_\_ At Risk  
\_\_\_\_ Unaffected Carrier

SOURCE OF CLINICAL INFORMATION: (check all that apply)  
\_\_\_\_ Personal Examination      \_\_\_\_ Hospital Records      \_\_\_\_ Genetics Clinic  
Record  
\_\_\_\_ Specialists Report      \_\_\_\_ Autopsy Record      \_\_\_\_ Private Physician  
\_\_\_\_ Other \_\_\_\_\_

### CLINICAL MANIFESTATIONS SUMMARY:

Please append a clinical description or case history that provides sufficient detail to establish the diagnosis and to confirm any specific features that distinguish this subject. As appropriate include diagnostic (biochemical, molecular, radiologic) test results for the subject from whom the sample came and for family members if available. Indicate if a Clinical Summary attached:  
\_\_\_\_ Yes      \_\_\_\_ No

If a summary is not available, please provide the rationale for the diagnosis in the space below:

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If available, please include a detailed pedigree.

Has this patient/family been reported in the literature?

Yes  No  Don't Know

Please cite reference(s): \_\_\_\_\_

Have other specimens from this family been stored in the Coriell Cell Repositories?

Yes  No

If yes, what are their Repository numbers and what are their relationships?

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## **SPECIMEN INFORMATION**

### **DIAGNOSTIC LABORATORY TESTS AND STUDIES:**

Have Biochemical Assays Been Performed On This Specimen?  Yes  No

Type of Assay: \_\_\_\_\_

Method Used (Please cite reference): \_\_\_\_\_

Results (also indicate normal range): \_\_\_\_\_

Have Molecular Tests Been Performed On This Specimen?  Yes  No

Chromosome/Gene locus: \_\_\_\_\_

Allele 1 \_\_\_\_\_

Allele 2 \_\_\_\_\_

Have Cytogenetic Analyses Been Performed On This Specimen?  Yes  No

Karyotype: (Current ISCN Nomenclature): \_\_\_\_\_

Number of cells analyzed: \_\_\_\_\_

Modal chromosome number: \_\_\_\_\_



## RELEASE, PERMISSION, AND CONSENT FORM

I hereby grant permission for cells from this sample to be stored in the NIGMS Human Genetic Cell Repository and for progeny cells and derived DNA to be distributed to qualified investigators.

Appropriate IRB-approved informed consent has been obtained from the donor subject and an unsigned copy of this consent form is attached.

No biopsies or cell cultures submitted to the Repository are to be obtained from a live fetus, defined by the presence of pulse, circulation, and other vital signs.

Date            /      /        
            Month/ Day /Year

Submitter \_\_\_\_\_

Address \_\_\_\_\_

Telephone# \_\_\_\_\_

Fax# \_\_\_\_\_

e-mail address \_\_\_\_\_

Submitter's Signature \_\_\_\_\_

To encourage storage of valuable cell cultures in the Repository, provision has been made for delayed release to other investigators if the submitter so desires. Please check your preference:

Release only to submitter or designee during the first year     Yes     No  
Mail completed form with the submission to:

Coriell Cell Repositories  
403 Haddon Avenue  
Camden, New Jersey 08103

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### To contact the CORIELL CELL REPOSITORIES:

**Write:** 403 Haddon Avenue; Camden, New Jersey 08103; USA

**Call:** 800-752-3805 in the United States; 856-757-4848 from other countries

**Fax:** 856-757-9737

**e-mail:** ccr@coriell.or