## Checklist for Shipping Samples to Dr. Boyd's Lab

Please fill out appropriately and check all boxes that apply. **Include** this form with the samples you send. Thank You.

☐ **PROBAND**

Name/Sample Code: ______________________DOB: _____________

Diagnosis: ______________________ Sex: ☐ male ☐ female

Race: ________________ Hotspot: _______________________

☐ syndromic ☐ non-syndromic

Associated Anomalies/Developmental Delay: _______________________

☐ **MOTHER**

Name/Sample Code: ______________________DOB: _____________

Diagnosis: ______________________

Race: ________________ Hotspot: _______________________

☐ syndromic ☐ non-syndromic

Associated Anomalies/Developmental Delay: _______________________

☐ **FATHER**

Name/Sample Code: ______________________DOB: _____________

Diagnosis: ______________________

Race: ________________ Hotspot: _______________________

☐ syndromic ☐ non-syndromic

Associated Anomalies/Developmental Delay: _______________________

☐ **OTHER** _____________________________

Name/Sample Code: ______________________DOB: _____________

Diagnosis: ______________________ Sex: ☐ male ☐ female

Race: ________________ Hotspot: _______________________

☐ syndromic ☐ non-syndromic

Associated Anomalies/Developmental Delay: _______________________

☐ **SIGNED CONSENT FORMS OBTAINED**

The above named patients have enrolled in a research project investigating the cause of craniosynostosis. They and/or their guardian(s) have given their informed consent to be in this study. A signed consent form has been filed by Dr. _________ and his research team and is identified by the subject code listed above.

Name: ________________________ Date: ___________

If you have any questions please contact Dr. Simeon Boyd at sboyd@ucdavis.edu or ph: 916-703-0454 fax: 916-703-0370.

**Mail samples and documents to:**
**Attn: Boyd Lab**
**UC Davis**
**4625 2nd Avenue**
**Room 1204**
**Sacramento, CA 95817**