



PATIENT INFORMATION

Last Name First MI
Parent Name (if pt is a minor)/Spouse
DOB Gender: Male Female Unknown
Address
City State Zip
Preferred Phone#
Is this #: Home Work Cell Other:
Other # where pt. can be reached
SS# Pt. ID/Med Rec#

Ethnicity of Pt. (circle all that apply): African-American Asian
Caucasian/NW European Eastern Indian Hispanic Jewish-Ashkenazi
Jewish-Sephardic Mediterranean Native American
Native Hawaiian/Other Pacific Islander Other:

PHYSICIAN ORDERING TEST

Name
Practice Name
Address
City State Zip
Preferred Phone #
FAX#
Genetic Counselor Phone

REFERRING HOSPITAL or LABORATORY

Name
Contact
Address
City State Zip
Preferred Phone#
FAX#

DUPLICATE REPORTS TO:

Name
Address
City State Zip
Preferred Phone#
FAX#

SPECIMEN INFORMATION

Date
Collected Time AM/PM

SAMPLE TYPE

Serum(S) Urine(U) Blood(B) Plasma(P) POC
Fibroblast Cult(FC) Amniotic Fl(AF) Blood Spot Card(BS) CSF
Skin(SK) DNA Chorionic Villi(CV) Muscle(M) Buccal Cells(BC)
Leukocyte Pellet (L) Other:

FOR SPECIMEN REQUIREMENTS: WWW.GENETICSLAB.EMORY.EDU

REASONS FOR REFERRAL/CLINICAL DIAGNOSIS:

Indication: Diagnostic Carrier

PREVIOUS TEST RESULTS: (Please attach copies.)

FAMILY HISTORY:

ICD-9 CODE

MEDICATIONS: anticonvulsants antidepressants antibiotics
HAF/TPN carnitine oral contraceptives Other
DIET: formula MCT oil breast milk special diet:

IS THIS PATIENT / SPOUSE / FAMILY MEMBER PREGNANT? NO YES (circle above)

IF YES, COMPLETE BELOW:

Gestational Age: by LMP wks by U/S wks
LMP EDC Proband's Genotype
Mother's Genotype Father's Genotype

Table with columns: Rec/d, Unboxed by, Sender, TEMP, SPECIMEN, COLOR, #TUBES, COMPLETE, INC, PT. DATA, TEST DATA, LABELS

TESTS ORDERED (continued on page 2)

Table with columns: Order, CYTOGENETIC TESTING: CHROMOSOME ANALYSIS, Test Code, Specimen. Includes tests like Amniotic fluid, Chorionic villi, Fetal blood, etc.

Table with columns: Order, CYTOGENETIC TESTING: FISH Analysis, Test Code, Specimen. Includes tests like Chromosome 15 duplication, Cri-du-Chat, etc.

*Special Account Set-Up & Consent Required Before Ordering

(10/18/07)



EMORY GENETICS LABORATORY GENERAL TEST REQUISITION FORM - Page 2 of 3

PATIENT NAME: Last _____ First _____ MI _____

For sequential testing, indicate in the 'Order' column, the numerical order for testing to be processed. Example: (1) MCADD Mutation Panel, (2) MCADD Gene Sequencing indicates that (1) MCADD mutation panel will be run first. If NEGATIVE, (2) MCADD gene sequencing will be added.

NOTE: Call to discuss prenatal molecular genetic testing with the laboratory genetic counselor PRIOR to sending a prenatal sample. 5 ml maternal blood in an EDTA (purple top) tube MUST accompany a prenatal specimen.

Order	BIOCHEMICAL GENETIC TESTING Analytes & Metabolic Profiles	Test Code	Specimen
	Acylcarnitine Profile	AR	P
	Amino Acids, Quantitative	AA, ED	P, CSF
	Amino Acids, Quantitative	UA	U
	Amino Acids – for PKU/MSUD	FP	BS
	Carnitine Concentration	CN, UC	P, U
	Coenzyme Q10	CQ	P
	Galactitol	GL	U
	Galactose-1-phosphate	GP	RBC
	Genetic Metabolic Panel (amino acids, organic acids, carnitine, acylcarnitine)	MW	P, U
	Homocysteine, Total	HO	P
	Methylmalonic Acid	MQ	P,U
	Mucopolysaccharide Screen, GAGs	GA	U
	Oligosaccharide Screen	OS	U
	Organic acids Analysis	OA	U
	Orotic Acid	OT	U
Order	Galactosemia Enzyme Assays	Test Code	Specimen
	Comprehensive Galactosemia Panel (GALT, Gal-1-P, isozyme, genotype)	GS	B,
	Galactosemia Biochemical Phenotype (GALT, isozyme)	GT	B
	Epimerase (UDP Galactose-4-Epimerase)	EP	RBC
	Galactokinase	GK	RBC
	Galactosemia Carrier Testing (GALT, isozyme, genotype)	GR	B
Order	Lysosomal Enzymes	Test Code	Specimen
	Screening Panel - 9 enzymes (see * below)	LS	B,L
	Metachromatic Leukodystrophy * (arylsulfatase A)	LA	B,L
	Alpha-Fucosidosis (Alpha-fucosidase) *	LP	B,L
	Fabry (Alpha-galactosidase) *	LB	B,L
	GM1/Morquio B, MPS IVb (β-galactosidase)*	LO	B,L
	Gaucher (Beta-glucosidase) *	LG	B,L
	α-Mannosidosis (Alpha-mannosidase) *	LM	B,L
	B-Mannosidosis (Beta-mannosidase) *	LN	B,L
	MPS VII (Beta-glucuronidase) *	LQ	B,L
	MPS I (Alpha-iduronidase)	LR	B,L
	Pompe (Acid maltase, GSD Type II)	DW, DZ	B, DBS, L
	Tay-Sachs (Hex A) *	HC	B,L
Order	Other Enzyme Assays	Test Code	Specimen
	BCKD assay (Maple Syrup Urine Disease)**	BC	B, FC, CV, AF
	Biotinidase [Control required. Refer to Website]	BX	S
	Gaucher Biomarker Panel	BM	B, S
	Gaucher Disease - ACE	AG	B, S
	Gaucher Disease - CHITO	CZ	B, S
	Gaucher Disease - TRAP	TT	B, S

Order	MOLECULAR GENETIC TESTING Ashkenazi Jewish Disease Screening	Test Code	Specimen
	Comprehensive Carrier Screening Panel	AJ	B
	Gaucher Disease, 8 Mutation Panel	GU	B
Order	MOLECULAR GENETICS TESTING Blindness	Test Code	Specimen
	OPA1, Autosomal dominant optic atrophy	DL	B
	OPA1 - Deletion/Duplication Array CGH	KO	B
	OPA3, Autosomal dominant optic atrophy	AF	B
	OPA3 - Deletion/Duplication Array CGH	KN	B
	Leber Hereditary Optic Neuropathy (LHON)	QC	B
Order	Congenital Heart Disease	Test Code	Specimen
	NKX2.5 Gene Sequencing	DK	B
	NKX2.5 – Deletion/Duplication Array CGH	KP	B
Order	Cystic Fibrosis	Test Code	Specimen
	CFTR Mutation Panel	CF	B
	CFTR Gene Sequencing – When above is negative	JK	B
	CFTR - Deletion/Duplication Array CGH	JL	B
Order	Growth Disorders	Test Code	Specimen
	Beckwith-Wiedemann Panel: H19 & Lit1	BW	B
	Beckwith-Wiedemann: H19 methylation	RT	B
	Beckwith-Wiedemann: Lit1 methylation	BL	B

Order	MOLECULAR GENETICS TESTING Growth Disorders	Test Code	Specimen
	Russell-Silver Panel: H19 methylation & UPD 7	RU	B
	MATERNAL BLOOD REQUIRED		
	Russell-Silver: H19 methylation	RT	B
	Russell-Silver Panel: PARENTAL CONTROL	DN	B
Order	Hearing Loss	Test Code	Specimen
	Hearing Loss Panel - Comprehensive: Cx-26 & Cx-30 sequencing, Cx-30 deletion, mitoc hearing loss	HL	B
	Cx-26 & Cx-30 Sequencing with Cx-30 Deletion	SX	B
	Connexin-30 Sequencing	FL	B
	Mitochondrial Hearing Loss	QJ	B
Order	Hemoglobinopathies	Test Code	Specimen
	Sickle Cell Anemia	HS	B
	Alpha Thalassemia	AT	B
Order	Infertility	Test Code	Specimen
	FMR1-Related Premature Ovarian Failure	FK	B
	Female Infertility Panel (chrom., FMR1-related POF)	MG	B
	Male Infertility Panel (chrom, CF, Y-microdeletion)	MH	B
	Y Chromosome Microdeletions	YD	B
Order	Mental Retardation	Test Code	Specimen
	Fragile X (CGG repeat + methylation)-order first	FR, FY	B
	FMR1 Sequencing (Fragile X Syndrome) – order when Fragile X test above is negative	FU	B
	FMR1 - Deletion/Duplication Array CGH	KQ	B
	Mowat-Wilson - Sequencing ZEB2 & FISH	MN	B
	MeCP2 (Rett Syndrome) Gene Sequencing	SR	B
	MeCP2 - Deletion/Duplication Array CGH	KT	B
Order	Methylation Studies	Test Code	Specimen
	Prader Willi Syndr. (Order this first to r/o PWS)	PW	B
	Angelman Syndr. (Order this first to r/o AS)	PW	B
Order	Mitochondrial Diseases	Test Code	Specimen
	Chronic Progress. Exter.Ophthalmol. (CPEO)	QB	B, M
	Kearns-Sayre Syndrome	QB	B, M
	Leigh Disease	QD	B, M
	Leber Hereditary Optic Neuropathy (LHON)	QC	B
	Mitochondrial Genome Deletion - Southern Blot	ML	B, M
	Mitochondrial Encephalopathy, Stroke and Lactic Acidosis (MELAS)	QA	B, M
	Myocl. Epil. & Ragged-Red Fiber (MERRF)	QH	B, M
	Pearson Marrow-Pancreas Syndrome	QB	B, BM
	Retinitis Pigmentosa and Ataxia (NARP)	QK	B, M
	Mitochondrial Full Genome Sequencing- mitochondrial disease specific testing (above) recommended first, if clinically indicated	JD	B, M
Order	Movement Disorders	Test Code	Specimen
	FMR1 Associated Tremor/Ataxia (FXTAS)	FJ	B
	Huntington Disease (*Requires consent)	HT	B
Order	Neuromuscular Disorders	Test Code	Specimen
	Dystrophin Array CGH – DMD/BMD del/dup**	EG	B
	Dystrophin Resequencing Array – DMD/BMD**	EE	B
	Congenital Hypotonia Panel (SMA, PWS, DM)	HY	B
	McArdle Disease	MA	B
	Myotonic Dystrophy (DM)	MD	B
	Spinal Muscular Atrophy (SMA)	SM	B
Order	Sex Determination	Test Code	Specimen
	Y-chromosome Detection	DY	B
Order	Twin Zygosity	Test Code	Specimen
	Zygosity Testing	ZT	B
Order	Custom Diagnostics	Test Code	Specimen
	Targeted mutation testing for previously identified mutations. Call to arrange before sending prenatal samples. (Include a copy of the results). Gene: _____ Carrier _____ Prenatal _____ Name of Family Members & Relationship: _____	KM, EI, EJ, EK, EM, EN, EQ	B, AF, CVS
Order	Other	Test Code	Specimen
	Sequencing is available for lysosomal storage disorders and inherited metabolic disorders. Please refer to the website for the appropriate test requisition.		



EMORY GENETICS LABORATORY – PAYMENT OPTIONS - Page 3 of 3

2165 N. Decatur Rd., Atlanta, GA 30033 • (404)778-8500 or 1-800-366-1502 • FAX (404)778-8559 • www.geneticslab.emory.edu

PATIENT NAME: Last _____ First _____ MI _____

Submit this completed payment options form with the specimen. For insurance billing, submission of the Patient Insurance Benefit Verification/Authorization Form prior to sending the sample is encouraged. Billing policy information is available on our website at www.geneticslab.emory.edu. Please call the billing office at (404)778-8580 or (800)366-1502 with questions or to establish an institutional account.

1. Self-Pay Cashier Check Visa MasterCard Amount: \$ _____
Credit Card #: _____ Expiration Date: ____/____/____
Cardholder Name: _____
Cardholder Billing Address _____ Zip: _____
Cardholder Signature: _____ Date: _____

2. Insurance (Includes Wellcare, Amerigroup and Peachstate for GA Residents)
Front and back copy of insurance card and insurance authorization must be included. Enclose a completed Patient Insurance Verification Form, if not previously submitted.
Policyholder Name: _____ SS# _____ DOB ____/____/____
Relationship to the Patient: Self Spouse Dependent Other _____
Gender: Male Female
Name of Primary insurance _____
Name of Secondary Insurance _____
Authorization Number: _____

3. Georgia Medicaid (Include front and back copy of Medicaid card)
EGL DOES NOT ACCEPT NON-GEORGIA MEDICAID

4. Bill Referring Client/Institution:
Contact Name: _____ Phone: _____
Client ID Number: _____ Fax: _____
Institution: _____
Address: _____
Authorized Signature: _____ Date: ____/____/____

5. International Samples:
Payment must be received with the sample. Payment by credit card can be indicated under option 1 above. Banker's checks or money orders must be made payable to Emory Genetics Laboratory. Please contact the EGL billing office for further arrangements at (404)778-8580 or (800)366-1502.

Authorization to contact health insurance carrier, and release confidential medical information:

I understand Emory Genetics Laboratory will contact my insurance carrier regarding coverage of genetic testing. I authorize the disclosure of insurance benefit coverage and payment information to Emory Genetics Laboratory. I authorize my physician or other medical entity to release confidential medical information to Emory Genetics Laboratory concerning my medical history. I authorize Emory Genetics Laboratory to release confidential medical information to my health insurance carrier to facilitate reimbursement of my medical fees.

Authorization to assign benefits, and accept financial responsibility for my account:

I assign and authorize insurance payments to Emory Genetics Laboratory. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State or Federal law. A duplicate or faxed copy of this authorization is considered the same as the original document.

Signature of Patient or Guardian: _____ Date: ____/____/____

Printed Name of Patient or Guardian: _____ Date: ____/____/____