EMORY GENETICS LABORATORY

GENERAL TEST REQUISITION FORM

2165 North Decatur Road Decatur, Georgia 30033
Phone: 855-831-7447 | 404-778-8499
Fax: 404-778-8559
http://geneticslab.emory.edu

PATIENT INFORMATION

Last Name _____

First Name _____ **MI**____

Parent name (if pt is a minor)/Spouse_____

Pt. ID/Med Rec# _____

DOB _____/_____/_____ (MM/DD/YYYY)

Gender ☐ Male ☐ Female ☐ Unknown ☐ Ambiguous

Ethnicity of pt. (check all that apply)

☐ African-American ☐ Asian

☐ Caucasian/NW European ☐ E. Indian ☐ Hispanic ☐ Jewish-Ashkenazi

☐ Jewish-Sephardic ☐ Mediterranean ☐ Native American

☐ Native Hawaiian/Other Pacific Islander ☐ Other _____

Address _____

_____

City _____ **State** _____ **Zip** _____

Preferred Phone (_____) _____ - _____

Secondary Phone (_____) _____ - _____

ENTITY ORDERING TEST (Fax # Required to Receive Report)

☐ **Physician**

Name_____

NPI _____

Phone (_____) _____ - _____**Fax** (_____) _____ - _____

Email _____

☐ **Laboratory/Institution**

Name_____

Address _____

Address 2: _____

City _____ **State** _____ **Zip** _____

Phone (_____) _____ - _____**Fax** (_____) _____ - _____

Email _____

DUPLICATE REPORTS TO (Fax # Required to Receive Report)

☐ **Genetic Counselor**

Name _____

Phone (_____) _____ - _____**Fax** (_____) _____ - _____

Email_____

☐ **Other**

Name_____

Phone (_____) _____ - _____**Fax** (_____) _____ - _____

Email _____

BILLING INFORMATION *Required*

ICD9 Codes:

Please complete billing information on page 2 of this form.

SPECIMEN INFORMATION

Date Collected _____ / _____ / _____ (MM/DD/YYYY)

Time _____ : _____ ☐ AM ☐ PM

SAMPLE TYPE

☐ Whole Blood ☐ Saliva ☐ DNA ☐ Muscle Biopsy ☐ Skin Biopsy ☐ DBS

☐ Serum ☐ Urine ☐ Plasma, Hep ☐ Plasma, EDTA ☐ Plasma, Other

☐ Leukocyte Pellet ☐ CSF ☐ Cult Fibroblast ☐ PUBS ☐ Other _____

PRENATAL SAMPLE TYPE

☐ Amniotic Fluid ☐ Cultured Amniotic Fluid ☐ POC

☐ Chorionic Villus ☐ Cultured Chorionic Villus ☐ DNA From _____

CLINICAL INFORMATION *REQUIRED*

Clinical findings/family history/test results (attach copies if appropriate)

Indication ☐ Diagnostic ☐ Carrier

Is patient/spouse/family member pregnant?

☐ No ☐ Yes **Check if relevant** ☐ Egg donor ☐ Sperm donor

LMP_____ **EDD**_____

Genotypes

Proband _____

Mother _____

Father _____

Diet

☐ Formula ☐ MCT Oil

☐ Breast Milk ☐ Hyperal

☐ Special _____

Medications

☐ Anticonvulsants ☐ Antidepressants ☐ Antibiotics ☐ HAF/TPN

☐ Carnitine ☐ Oral Contraceptives ☐ Other _____

Has Patient had any of the following?

☐ Transfusion ☐ Bone Marrow Transplant

FOR LAB USE ONLY

Rec/d_____/_____/_____ **Unboxed By** _____

Sender_____

TEMP	SPECIMEN	COLOR	# TUBES		COMP.	INCOMP.
R C F				**PT. DATA**	[ ]	[ ]
R C F				**TEST DATA**	[ ]	[ ]
R C F				**PHYSICIAN DATA**	[ ]	[ ]
R C F				**BILLING DATA**	[ ]	[ ]

BILLING

[ ] Facility Bill Acct # _____

[ ] Insurance Bill

[ ] Self-Pay

Hold Billing _____

QC _____

Reflex _____

Specimen _____

Accessioned by: Labeled by: Pickup:

INFORMATION FOR HEALTH CARE PROVIDERS AND PATIENTS

Emory Genetics Laboratory retains patient samples indefinitely for validation, educational purposes and/or research. For molecular cytogenetic and some molecular genetic tests, submitted clinical information and test results are also included in HIPAA-compliant, de-identified public databases as part of the National Institute of Health's effort to improve diagnostic testing and our understanding of the relationships between genetic changes and clinical symptoms (for information about the molecular cytogenetic database, visit the consortium website at https://www.iscaconsortium.org/ and for information about the molecular genetic database refer to the individual test descriptions). Confidentiality of each sample is maintained. Patients may request to withdraw consent for the storage of their sample and/or use of the data by: 1) calling the laboratory at 1-855-831-7447 and asking to speak with a laboratory genetic counselor or 2) visiting our website at http://www.geneticslab.emory.edu/opt-out.

[ ] Refusal for inclusion in these efforts may be indicated by checking this box. (If the box is not checked the data will be anonymized and used.)

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Submit this completed payment options form with the specimen. Testing is not initiated until billing information is received. Billing policy information is available at http://geneticslab.emory.edu/billing.

PAYMENT OPTIONS (please select one of the following options)

1 - ☐ INSTITUTION

*For new clients, to establish an institutional account, you must complete an Institutional Account Request Form **prior** to submitting an order. The form can be downloaded at http://geneticslab.emory.edu/billing. For any questions or to confirm whether you have an account or what your account number is, please contact our billing office at 404-778-8580 or by email at eglbilling@emory.edu.*

Institution _____ Account # _____

The following information is not required if account number is provided above:

Contact Name _____ Email _____

Billing Address _____

City _____ State _____ Zip _____

Phone_____ Fax _____

EGL Billing Label
Please call to request labels

2 - ☐ SELF PAY

☐ Cashier Check ☐ Visa ☐ MasterCard ☐ Discover

Amount $_____ (include discount if applicable)

Credit Card # _____ Expiration Date _____/_____

Cardholder Billing Address _____

City _____ State _____ Zip _____

Cardholder Phone _____

Required for credit card payments

_____
Cardholder Printed Name as it Appears on Card

_____
Cardholder Signature

3 - ☐ INSURANCE (Also includes Wellcare, Amerigroup, Peachstate for GA Residents, Medicare, and GA Medicaid). EGL does not accept any out-of-state Medicaid.

*A **legible** front and back copy of insurance card and insurance authorization must be included. A completed Advance Beneficiary Notice of coverage (ABN) is required for Medicare patients.*

ICD9 Diagnosis Code(s) *Required _____

PRIMARY Policyholder Name _____ DOB ____/____/_____

Relationship to the Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____ Gender ☐ Male ☐ Female

Insurance Co. Name _____ Policy No. _____ Group No. _____

Address _____

City _____ State _____ Zip _____

Phone _____ Authorization Number (Copy of authorization letter also required) _____

SECONDARY Policyholder Name _____ DOB ____/____/_____

Relationship to the Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____ Gender ☐ Male ☐ Female

Insurance Co. Name _____ Policy No. _____ Group No. _____

Address _____

City _____ State _____ Zip _____

Phone _____ Authorization Number (Copy of authorization letter also required) _____

Authorization to assign benefits, accept financial responsibility, and disclose health records

If I am entitled to benefits under the Medicare program, or any insurance policy or other health benefit plan, in consideration for services provided to me by EGL, I assign, transfer and convey the benefits payable under such program, policy or plan for such services to EGL. I authorize payment of benefits directly to EGL, with such benefits applied to my bill. I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me and I agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, not pre-certified or not preauthorized by my insurance plan. I understand that EGL is permitted to disclose my health information for purposes of payment of bills (if I filled out section 3 above), my continued care or treatment, and healthcare operations.

Signature of Patient, Parent, or Guardian: (Required)_____ **Date** _____/_____/_____

INTERNATIONAL SAMPLES

Payment in full must be made before samples will be processed. Prepaid samples may receive a discount when required payment is received with the sample. Please visit our website for more information: http:geneticslab.emory.edu/billing/international. Payment by credit card can be indicated under option 2 above. Banker's checks or money orders must be made payable to Emory Genetics Laboratory. Please contact the EGL billing office for further arrangements or when you make an electronic fund payment at 404-778-8580 or eglbilling@emory.edu.

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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.

BIOCHEMICAL GENETIC TESTING

Order	Code	Congenital Disorders of Glycosylation - Biochemical
	BCDGP	CDG: Panel (Transferrin and N-glycan Analysis), Plasma
	BCDGS	CDG: Carbohydrate Deficient Transferrin, Plasma
	BNGLY	CDG: N-glycan Profile, Plasma
	BOGLY	CDG: O-Glycan Profile, Quantitative and Qualitative, Plasma
	OS	High Resolution Oligosaccharide/Glycan Profile, Urine
Order	**Code**	**Galactosemia (Comprehensive)**
	GS	Galactosemia, Classic: Panel (GALT Activity & Gal-1-P), RBC *If enzyme testing comes back abnormal and you would like to automatically reflex to GALT full gene sequencing, please select test code SG below.*
	GR	Galactosemia, Classic: Carrier Testing (GALT Activity), RBC *If enzyme testing comes back abnormal and you would like to automatically reflex to GALT full gene sequencing, please select test code SG below.*
	GT	Galactosemia, Classic: GALT Activity, RBC
[ ] Seq [ ] Del/Dup	SG DGALT	Galactosemia - *GALT* Gene Sequencing
	GP	Galactosemia: Gal-1-P, RBC
	GL	Galactosemia: Galactitol, Urine
Order	**Code**	**Lysosomal Storage Disorders - Enzyme**
	LS	LSD: Enzyme Panel (13 enzymes), WBC
Order	**Code**	**Lysosomal Storage Disorders - Screening and Monitoring**
	BLSDS	LSD: Screening (GAGs & Oligosaccharides), Urine Includes Test Codes GA & OS
	GA	MPS: GAGs, Quantitative & Qualitative, Urine
	BM	Gaucher Disease: Biomarker Panel (ACE, CHITO, TRAP), Serum
Order	**Code**	**Metabolic and Analyte Studies**
	MW	Metabolic Disease: Panel, Plasma & Urine Includes Test Codes AA, AR, CN, & OA
	BNBSF	Abnormal NBS (Elevated C3): Panel, Plasma & Urine Includes Test Codes AA, AR, CN, OA, & HO
	AR	Acylcarnitine Profile, Plasma
	ED	Amino Acid Profile, CSF
	AA	Amino Acid Profile, Plasma
	UA	Amino Acid Profile, Urine
	BCAHP	CAH: Steroid Profile, DBS
	CN	Carnitine Profile, Plasma
	UC	Carnitine Profile, Urine
	CQ	CoQ10, Plasma
	BCQLC	CoQ10, WBC
	BHOBS	Homocysteine, Total, DBS

Order	Code	Metabolic and Analyte Studies
	HO	Homocysteine, Total, Plasma
	BMMAD	MMA & MCA, Quantitative, DBS
	MQ	MMA, Quantitative, Plasma
	BMMAU	MMA, Quantitative, Urine
	BMSUD	MSUD: Allo-isoleucine & BCAA, DBS
	OA	Organic Acid Profile, Quantitative & Qualitative, Urine
	OT	Orotic Acid, Quantitative, Urine
	ZF	Pyruvic Acid, Quantitative, Blood
	ZE	Pyruvic Acid, Quantitative, CSF
	BSLOS	SLO: Sterol Profile, Plasma
Order	**Code**	**Other Enzyme Assays**
	BX	Biotinidase Deficiency: Biotinidase Activity, Serum
	ZU	MSUD: BCKD Activity, Fibroblasts
	BC	MSUD: BCKD Activity, Lymphoblasts

CYTOGENETIC TESTING

Order	Code	Chromosomal Microarray
	VA	EmArray Cyto
	CMSNP	CytoScan SNP Array
	CMPOC	CytoScan SNP Array POC (MCC not included but recommended)
	CMCCS	Maternal Cell Contamination (MCC)
Order	**Code**	**Chromosome Analysis**
	CV	Chorionic Villi
	CA	Peripheral Blood, Age: 6 months and above
	CB	Peripheral Blood, Age: less than 6 months
	AD	Amniotic Fluid (includes AFP with reflex to ACHE)
	MM	Peripheral Blood, Mosaicism study
	CP	Fetal Blood (PUBS)
	CO	Products of Conception (EmArray Cyto POC recommended as first tier)
	FS	Targeted Family Member Study (attach report)
Order	**Code**	**FISH STAT**
	RS	Prenatal FISH - Aneuploidy (13,18, 21, X&Y)
	CFXYS	X and Y (ambiguous genitalia)
	CF22S	22q11 microdeletion (DiGeorge, VCF)
	CF13S	Trisomy 13
	CF18S	Trisomy 18
	CF21S	Trisomy 21
Order	**Code**	**FISH Standard**
	PA	FISH Analysis with Culture (Also indicate probe below, if probe not listed, check other)
	FI	FISH Analysis without Culture (Also indicate probe below, if probe not listed, check other)
		Array Confirmation/Family Studies Custom Other: _____
		Wolf-Hirschhorn (4p-)
		Cri-du-Chat (5p-)
		Williams (7q11.2 del)

Highlighted test names indicate panel tests.

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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	Code	FISH Standard
		Prader-Willi/Angelman (Order after DNA methylation)
		Smith-Magenis (17p11.2 del)
		Miller-Dieker, lissencephaly (17p13)
		17q21 Microdeletion Syndrome
		22q11.2 deletion, DiGeorge/VCF (reflex test if heart defect on fetal u/s)
	TL	Telomere Panel
Order	**Code**	**Other Cyto Tests**
	TC	Tissue Culture
		MOLECULAR GENETIC TESTING
Order	**Code**	**Cardiac Disorders**
	MCAR1	Cardiomyopathy- Sequencing & Deletion/Duplication Panel
	MM093	Arrhythmias - Sequencing Panel
	MM096	Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy- Sequencing & Deletion/Duplication Panel
	MM095	Brugada Syndrome- Sequencing Panel
[ ] Seq [ ] Del/Dup	SCACN DCACN	*CACNA1C*-related Disorders - *CACNA1C* Gene Sequencing
	MM092	Dilated Cardiomyopathy - Sequencing & Deletion/Duplication Panel
	MM091	Hypertropic Cardiomyopathy - Sequencing & Deletion/Duplication Panel
[ ] Seq [ ] Del/Dup	DK KP	Isolated Nonsyndromic Congenital Heart Disease - *NKX2-5* Gene Sequencing
	MM094	Long and Short QT Syndrome- Sequencing Panel
[ ] Seq [ ] Del/Dup	SMAP1 DMAP1	*MAP2K1*-related Disorders - *MAP2K1* Gene Sequencing
	MM099	Marfan Syndrome, Thoracic Aortic Aneurysm & Dissection (TAAD), and Related Disorders- Sequencing Panel
	MM098	Pulmonary Arterial Hypertension- Sequencing Panel
[ ] Seq [ ] Del/Dup	SRYR2 DRYR2	*RYR2*-related Disorders - *RYR2* Gene Sequencing
	MM097	Sudden Cardiac Arrest (SCA)- Sequencing and Deletion/Duplication Panel
[ ] Seq [ ] Del/Dup	STPM1 DTPM1	*TPM1*-related Disorders - *TPM1* Gene Sequencing
	STTNX	*TTN*-related Disorders - *TTN* Gene Sequencing
Order	**Code**	**Ciliopathies**
	MCIL1	Ciliopathies - Sequencing & Deletion/Duplication Panel

Order	Code	Congenital Abnormality Syndromes
	CC061	1q21.1 Del/Dup Analysis
[ ] Seq [ ] Del/Dup	SBLM1 DBLM1	Bloom's Syndrome - *BLM* Gene Sequencing
[ ] Seq [ ] Del/Dup	SBRAF DBRAF	*BRAF*-related Disorders - *BRAF* seq
[ ] Seq [ ] Del/Dup	SMAP2 DMAP2	Cardiofaciocutaneous Syndrome, *MAP2K2*-related - *MAP2K2* Gene Sequencing
[ ] Seq [ ] Del/Dup	UH DCHD7	CHARGE Syndrome - *CHD7* Gene Sequencing
[ ] Seq [ ] Del/Dup	SHRAS DHRAS	Costello Syndrome - *HRAS* Gene Sequencing
[ ] Seq [ ] Del/Dup	SKDM6 DKDM6	Kabuki Syndrome - *KDM6A* Gene Sequencing
	MKABP	Kabuki Syndrome - *KMT2D* & *KDM6A* Gene Sequencing & Deletion/Duplication Panel
[ ] Seq [ ] Del/Dup	SMLL2 DMLL2	Kabuki Syndrome - *KMT2D* Gene Sequencing
[ ] Seq [ ] Del/Dup	ZG DKRAS	*KRAS*-related Disorders - *KRAS* Gene Sequencing
	SSPRE	Legius Syndrome: *SPRED1* Gene Sequencing
	MNOO1	Noonan Syndrome & Related Disorders - Sequencing Panel
[ ] Seq [ ] Del/Dup	SNRAS DNRAS	Noonan Syndrome - *NRAS* Gene Sequencing
[ ] Seq [ ] Del/Dup	UG DPTPN	Noonan Syndrome - *PTPN11* Gene Sequencing
[ ] Seq [ ] Del/Dup	SSOS1 DSOS1	Noonan Syndrome - *SOS1* Gene Sequencing
[ ] Seq [ ] Del/Dup	SRAF1 DRAF1	Noonan Syndrome: *RAF1* Gene Sequencing
[ ] Seq [ ] Del/Dup	SSHOC DSHOC	Noonan-like Syndrome with Loose Anagen Hair - *SHOC2* Gene Sequencing
[ ] Seq [ ] Del/Dup	SCREB DCREB	Rubinstein-Taybi Syndrome - *CREBBP* Gene Sequencing
	SEP30	Rubinstein-Taybi Syndrome - *EP300* Gene Sequencing
[ ] Seq [ ] Del/Dup	SDHCR DDHCR	Smith-Lemli-Opitz Syndrome- *DHCR7* Gene Sequencing
[ ] Del/Dup [ ] Seq	DRAI1 SRAI1	Smith-Magenis Syndrome- *RAI1* Gene Sequencing *(Order Deletion/Duplication testing before sequencing)*
[ ] Seq [ ] Del/Dup	SNSD1 DNSD1	Sotos Syndrome - *NSD1* Gene Sequencing
	XM060	TAR panel - Sequencing & 1q21.1 Deletion/Duplication Panel
	MS061	TAR Syndrome - *RBM8A* Gene Sequencing

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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	Code	Cornelia de Lange
[ ] Seq [ ] Del/Dup	SNIPB DNIPB	Cornelia de Lange Syndrome- *NIPBL* Gene Sequencing
[ ] Seq [ ] Del/Dup	SSMC1 DSMC1	Cornelia de Lange Syndrome- *SMC1A* Gene Sequencing
Order	**Code**	**Cystic Fibrosis**
	CF	Cystic Fibrosis - CFTR Common Mutation Panel
[ ] Seq [ ] Del/Dup	JK JL	Cystic Fibrosis - *CFTR* Gene Sequencing
Order	**Code**	**Eye Disorders**
	MM030	Eye Disorders - Comprehensive Sequencing & Deletion/Duplication Panel
[ ] Seq [ ] Del/Dup	SBEST DBEST	*BEST1*-related Disorders - *BEST1* Gene Sequencing
	MM131	Achromatopsia, Cone, & Cone-rod Dystrophy - Sequencing & Deletion/Duplication Panel
	MM135	Albinism - Sequencing & Deletion/Duplication Panel
	MM139	Anophthalmia/Microphthalmia/Anterior Segment Dysgenesis/Anomaly - Sequencing Panel
[ ] Seq [ ] Del/Dup	AF KN	Autosomal Dominant Optic Atrophy and Cataract - *OPA3* Gene Sequencing
[ ] Seq [ ] Del/Dup	DL KO	Autosomal Dominant Optic Atrophy, Kjer Type - *OPA1* Gene Sequencing
	MM132	Bardet-Biedl Syndrome - Sequencing and Deletion/Duplication Panel
[ ] Seq [ ] Del/Dup	SCHMX DCHMX	Choroideremia - *CHM* Gene Sequencing
	MM133	Congenital Stationary Night Blindness - Sequencing and Deletion/Duplication Panel
	MM134	Flecked-retina Disorders - Sequencing & Deletion/Duplication Panel
	SHPS1	Hermansky-Pudlak Syndrome - *HPS1* Gene Sequencing
[ ] Seq [ ] Del/Dup	SHPS4 DHPS4	Hermansky-Pudlak Syndrome - *HPS4* Gene Sequencing
[ ] Seq [ ] Del/Dup	SCNNM DCNNM	Jalili Syndrome - *CNNM4* Gene Sequencing
	MM136	Joubert Syndrome - Sequencing Panel
	MM137	Leber Congenital Amaurosis - Sequencing & Deletion/Duplication Panel
	QC	Leber Hereditary Optic Neuropathy (LHON) Screening - Targeted Mutation Analysis
	MM138	Macular Dystrophy / Degeneration / Stargardt Disease - Sequencing & Deletion/Duplication Panel
	MM231	Neuronal Ceroid-Lipofuscinoses - Sequencing Panel
	MM234	Optic Atrophy - Sequencing and Deletion/Duplication Panel

Order	Code	Eye Disorders
[ ] Seq [ ] Del/Dup	SPAX6 DPAX6	*PAX6*-related Disorders - *PAX6* Gene Sequencing
	MM233	Retinitis Pigmentosa - Sequencing & Deletion/Duplication Panel
	SDHDD	Retinitis Pigmentosa 59 - *DHDDS* Gene Sequencing
[ ] Seq [ ] Del/Dup	SRB1X DRB1X	Retinoblastoma - *RB1* Gene Sequencing
[ ] Seq [ ] Del/Dup	SRP20 DRP20	*RP2*-related X-linked Retinitis Pigmentosa - *RP2* Gene Sequencing
[ ] Seq [ ] Del/Dup	SRPGR DRPGR	*RPGR*-related X-linked Retinitis Pigmentosa - *RPGR* Gene Sequencing
	MM235	Senior-Loken Syndrome - Sequencing & Deletion/Duplication Panel
	MM236	Stickler Syndrome - Sequencing Panel
	MM237	Usher Syndrome - Sequencing Panel
	MM238	Vitreoretinopathy - Sequencing & Deletion/Duplication Panel
Order	**Code**	**Growth Disorders**
	XM010	Short Stature - CytoScan SNP Array, Russell-Silver Panel, UPD14 Analysis, Sequencing & Deletion/Duplication Panel
	XM011	Short Stature - SNP Array, Sequencing, & Deletion/Duplication Panel
	MM011	Short Stature - Russell-Silver Panel, UPD14 Analysis, Sequencing, & Deletion/Duplication Panel
	MM012	Short Stature Panel - Sequencing & Deletion/Duplication
	BW	Beckwith-Wiedemann - *H19 & LIT1* Methylation Panel
	ZP	Beckwith-Wiedemann: *H19* Methylation
	BL	Beckwith-Wiedemann: *LIT1* Methylation
	NZ	Russell-Silver - *H19* Methylation & UPD7 Panel
	NM	Russell-Silver Syndrome: UPD7
	RT	Russell-Silver: *H19* Methylation
	SSHOX	*SHOX*-related Haploinsufficiency Disorders - *SHOX* Gene Sequencing
Order	**Code**	**Hearing Loss**
	HL	Hearing Loss - *GJB2* & *GJB6* Sequencing, GJB6 Common Deletion, & Targeted Mitochiondrial Analysis Panel
[ ] Seq [ ] Del/Dup	SX PI	Hearing Loss: *GJB2* & *GJB6* - Gene Sequencing Panel *(Sequencing includes Cx30 common deletion)*
	OZ	Hearing Loss - *GJB2* sequencing
	FL	Hearing Loss - *GJB6* Gene Sequencing *(Includes Cx30 common deletion)*

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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	Code	Hearing Loss
	QJ	Hearing Loss - Targeted Mitochondrial Mutation Panel
	MM190	Hearing Loss - Sequencing Panel
Order	**Code**	**Hemoglobinopathies**
	AT	Alpha-Thalassemia - *HBA1* and *HBA2* Deletion Analysis
	HS	Sickle Cell Disease - HbS/HbC Mutations
Order	**Code**	**Infertility**
	MG	Female Infertility Panel - Chromosomes, *FMR1* - related POF
	XM050	Male Infertility Panel (Chromosomes, CF common mutation panel, Y-MicroDeletions)
	MFMR1	Premature Ovarian Insufficiency - *FMR1* CGG Repeat Analysis
	YD	Y-Chromosome - Microdeletion Analysis
Order	**Code**	**Methylation Studies**
	TU	Chromosome 6 Uniparental Disomy (UPD6) - Methylation Analysis
	PW	Prader Willi/Angelman - Methylation *(order before FISH)*
	OO	Uniparental Disomy of Chromosome 14 (UPD14) - Methylation Analysis
Order	**Code**	**Mitochondrial Disease**
	JD	Mitochondrial Full - Genome Sequencing (*one of above tests recommended first, if indicated*)
	ML	Mitochondrial Genome Deletions/Duplications - Southern Blot
	QD	Leigh Disease - Mitochondrial Deletions/Duplications and Targeted Mutation Analysis
	QA	Mitochondrial Encephalomyopathy - Lactic Acidosis (Stroke-like Episodes/MELAS)
	QH	Myoclonic Epilepsy and Ragged-Red Fiber Disease (MERRF) - Targeted Mutation Analysis
	ZN	Pearson Marrow-Pancreas Syndrome - Mitochondrial Deletions/Duplications
	QK	Retinitis Pigmentosa and Ataxia (NARP) - Targeted Mutations Analysis
Order	**Code**	**Molecular Testing**
	MM250	Brain Malformations- Sequencing Panel
	MM241	Bronchiectasis- Sequencing Panel
	MM244	Congenital Central Hypoventilation Syndrome- Sequencing Panel
	MM270	Connective Tissue Disorders- Sequencing Panel
	MM243	Cystic Lung Disease- Sequencing Panel
	MM160	Inflammatory Bowel Disease- Sequencing Panel
	MM340	Neonatal and Adult Cholestasis- Sequencing Panel

Order	Code	Molecular Testing
	MM240	Pulmonary Disease- Comprehensive Sequencing Panel
	MM242	Pulmonary Fibrosis and Hermansky-Pudlak Syndrome- Sequencing Panel
	MM170	Skeletal Dysplasia- Sequencing Panel
Order	**Code**	**Movement Disorders**
	SSETX	Ataxia with Oculomotor Apraxia Type 2 - *SETX* Gene Sequencing
	FJ	Fragile X-associated Tremor/Ataxia (FXTAS) - CGG Repeat Analysis
	HT	Huntington Disease - CAG Repeat Analysis (Requires Consent)
	SAT7B	Wilson Disease: *ATP7B* Gene Sequencing
Order	**Code**	**Neuromuscular Disorders**
	MM110	Congenital Myasthenic Syndromes- Sequencing Panel
Order	**Code**	**Peroxisomal Disorders**
	MM140	Peroxisome Biogenesis Disorders, Zellweger Syndrome Spectrum - Sequencing Panel
Order	**Code**	**Seizure Disorders**
	MEPI1	Epilepsy and Seizure Disorders - Sequencing & Deletion/Duplication Panel
	SGABR	Childhood Absence Epilepsy - *GABRB3* Gene Sequencing
[ ] Seq [ ] Del/Dup	SPNKP DPNKP	Early Infantile Epileptic Encephalopathy Type 10 - *PNKP* Gene Sequencing
[ ] Seq [ ] Del/Dup	SSLC2 DSLC2	Glucose Transporter Type 1 Deficiency Syndrome- *SLC2A1* Gene Sequencing
[ ] Seq [ ] Del/Dup	SRELN DRELN	Lissencephaly 2 - *RELN* Gene Sequencing
Order	**Code**	**Sex Determination**
	DY	Y-Chromosome - *SRY* Analysis
Order	**Code**	**Skin Disorders**
	SMSMO	*MSMO1*-related Psoriasiform Dermatitis - *MSMO1* Gene Sequencing
[ ] Seq [ ] Del/Dup	SZMPS DZMPS	*ZMPSTE24*-related Disorders - *ZMPSTE24* Gene Sequencing
Order	**Code**	**Twin Zygosity**
	ZT	Twin Zygosity - DNA-Based Testing
Order	**Code**	**Endocrine Disorders**
	MM220	Maturity Onset Diabetes of the Young (MODY) - Sequencing Panel
Order	**Code**	**Known Mutation Analysis**
	DKMDD	Familial Mutation Testing - Targeted Deletions/Duplications *(Please indicate mutation/s information on page 1)*
	KM	Known Mutation Testing - Targeted Sequencing *(Please indicate mutation/s information on page 1)*

Highlighted test names indicate panel tests.

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Patient Name: Last_____ First _____ MI _____

DISEASE SPECIFIC REQUISITIONS
Please reference the respective Disease-Specific Requisition for comprehensive testing options available in all three laboratories for the following disease categories: Autism/ID, Congenital Disorders of Glycosylation, Hereditary & Somatic Cancers Disorders, Lysosomal Storage Disorders, Metabolic Disorders & Newborn Screening, and Neuromuscular Disorders.

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 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	Code	Other Molecular Tests
	MM280	Neurology- Sequencing Panel
		OTHER
Order	**Code**	**Other**
[ ] Seq [ ] Del/Dup	SFOXG DFOXG	Congenital Variant Rett Syndrome- *FOXG1* Gene Sequencing
		OTHER TESTS
Order	**Code**	
		Other Test *(Please Specify):* _____

Highlighted test names indicate panel tests.