

Test Requisition

PATIENT INFORMATION:

Patient's Name	Social Security Number	
Requesting Institutions Patient ID Code	Gender	
Date of Birth	Date Collected	
*GeoAncestry/Ethnicity		
Has this patient or a family member been tested by PreventionGenetics for any other condition? If so, when (approximately) and which test?		
Other relevant clinical information (Positive MRI, contracture test, other genetic testing done, etc.)		
Reason for Testing / ICD-9 code		
1:	2:	3:

*Knowing the geoancestry, or the geographic origin of a patient's ancestors of about the time of Columbus (1500), can speed the identification of the specific mutation that the patient carries. A practical means of estimating a patient's geoancestry is to ask the geographical/ethnic origin of the patient's grandparents. Examples: German, Italian, Nigerian, Chinese, Hmong, Ashkenazi, Hispanic, Native American/Ojibwa. Many patients will have multiple origins. Please list all relevant information.

REPORTING ADDRESS (The test results will be sent to this address)

Requesting Physician / Genetic Counselor (please print legibly)	Contact phone number
Address:	
City, State, Zip Code	
Secure FAX number (only if you'd like the results faxed)	

BILLING INFORMATION (Required for all tests)

It is PreventionGenetics policy to bill the submitting Institution or Physician directly unless other arrangements are made prior to testing. PreventionGenetics does not direct bill insurance companies unless written preauthorization for the test is obtained in advance by the patient and/or their physician, and this written authorization is submitted to PreventionGenetics. If this test is to be paid directly by the patient or if there will be any balance left unpaid by the insurance company, credit card information must be provided.

Billing Institution / Contact / Patient (please print legibly)	Contact / Patient Phone Number
Address:	City, State, Zip Code

PreventionGenetics test menu is continually expanding. Please call or visit our web site for a current list of tests offered.

CLIA#: 52D1027685 • CAP#: 7185561

*****Important:** Please notify *PreventionGenetics* by fax or email when a sample is sent.***

This enables us to track your sample while in transit. Fax: 715-384-3661 Email: clinicaltesting@preventiongenetics.com

PATIENT INFORMATION:

Patient's Name (last, first, middle initial)	
Requesting Institutions Patient ID Code	Date of Birth

Please mark your selection clearly

<input checked="" type="checkbox"/>	<i>CCM1, CCM2 and CCM3</i> Genes Sequential Sequencing: Cavernous Malformations	<input checked="" type="checkbox"/>	<i>PTPN11</i> Gene, Targeted Exon Sequencing: Noonan Syndrome
<input type="checkbox"/>	<i>CCM1 / KRIT1</i> Gene Sequencing: Cavernous Malformations	<input type="checkbox"/>	<i>PTPN11</i> Gene, Targeted Exon Sequencing: LEOPARD Syndrome
<input type="checkbox"/>	<i>CCM2 / MGC4607</i> Gene Sequencing: Cavernous Malformations	<input type="checkbox"/>	<i>RYR1</i> Gene Sequential Sequencing: Malignant Hyperthermia
<input type="checkbox"/>	<i>CCM3 / PDCD10</i> Gene Sequencing: Cavernous Malformations	<input type="checkbox"/>	<i>RYR1</i> Gene Primary Exon Sequencing: Malignant Hyperthermia
<input type="checkbox"/>	<i>CCM1 / KRIT1</i> Gene, Exon 10 "Common Hispanic Mutation" Detection: Cavernous Malformations	<input type="checkbox"/>	<i>RYR1</i> Gene 3' Exon Sequencing: Central Core Disease/Malignant Hyperthermia
<input type="checkbox"/>	<i>FOXC2</i> Gene Sequencing : Lymphedema-Distichiasis Syndrome	<input type="checkbox"/>	<i>RYR1</i> Gene Extended Exon Sequencing: Malignant Hyperthermia
<input type="checkbox"/>	Genome Polymorphism Scan	<input type="checkbox"/>	<i>RYR2</i> Gene Selected Exon Sequencing: Catecholaminergic Polymorphic Ventricular Tachycardia
<input type="checkbox"/>	<i>GJB2 (Connexin26)</i> Gene Sequencing: Hereditary Deafness	<input type="checkbox"/>	The PreventionGenetics DNA Fingerprint Panel: Zygosity Testing, Parentage Testing, Laboratory Specimen Matching
<input type="checkbox"/>	<i>GLI3</i> Gene Sequencing: Pallister-Hall Syndrome and Greig Cephalopolysyndactyly Syndromes	<input type="checkbox"/>	The PreventionGenetics Sex Chromosome Polymorphism Panel
<input type="checkbox"/>	<i>GYS2</i> Gene Sequencing: Glycogen Storage Disease, Type 0	<input type="checkbox"/>	Thrombophilia Panel by Array Tape F2: Factor II Prothrombin G20210A Mutation F5: Factor V (Leiden) G1691A Mutation MTHFR: Methylenetetrahydrofolate Reductase Gene C677T Mutation
<input type="checkbox"/>	<i>G6PC</i> Gene Sequencing: Glycogen Storage Disease, Type 1a	<input type="checkbox"/>	DNA Banking
<input type="checkbox"/>	<i>HRAS</i> Gene Sequencing: Costello Syndrome	<input type="checkbox"/>	Selected Single Exon Sequencing for any of the genes listed. For all single exon testing, please indicate: Gene _____ Exon _____ Position, if known _____
<input type="checkbox"/>	<i>LMNA</i> Gene, Exon 11 "Common HGPS Mutation" Detection: Progeria	<input type="checkbox"/>	
<input type="checkbox"/>	<i>LMNA</i> Gene Sequencing: Emery-Dreifuss Muscular Dystrophy, Dilated Cardiomyopathy, Lipodystrophy Disorders, Limb-Girdle Muscular Dystrophy-Type 1B, Charcot-Marie-Tooth Disease-Type 2B1, Hutchinson-Gilford Progeria Syndrome	<input type="checkbox"/>	

SPECIMEN REQUIREMENTS:

- Collect 2-5 ml of whole blood in EDTA (purple top tube) or ACD (yellow top tube). 5 ml is the preferred volume.
- Only one blood tube is required for multiple tests.
- Ship whole blood specimens at room temperature.
- Do not freeze blood.
- During hot weather, include a frozen ice pack in the shipping container. Do not allow the ice pack to come in direct contact with the specimen tube.
- In cold weather, include an unfrozen ice pack to help moderate extremes in temperature. The DNA in whole blood is stable for at least 48 hours at 21°C, 5-7 days at 4°C.

For PreventionGenetics use only: PGID #: 05- _____ - _____
Date Received: _____ Received by: _____

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