PREVENTION GENETICS

DISEASE PREVENTION THROUGH GENETIC TESTING

Office use only

3800 S. Business Park Ave
Marshfield, WI 54449
Phone: 715-387-0484
Fax: 715-384-3661

CMA-ISCA/PGxome Test Requisition Form

(revised 4/8/2016)

Person completing form	*Contact Information (phone or email)*	*Date of Request*

Ordering Checklist (required):

- ☐ Proband (patient) specimen
- ☐ Family member specimen(s) – PGxome only
- ☐ Healthcare Provider Statement(s)
- ☐ Clinic notes, summary, and/ or relevant medical records
- ☐ Pedigree with family medical health history
- ☐ Previous genetic testing results (where available)

Proband Information

Patient's Last (Family) Name	*First Name*	*MI*	*Date of Birth:* *Month* *Day* *Year*
Patient ID Code	*Date Collected:* *Month* *Day* *Year*		*Gender:* ☐ Male ☐ Female ☐ Other
Specimen Source: ☐ *Whole blood* ☐ *Extracted DNA Source:* ☐ *Cultured Cells Source:* ☐ *Tissue Source:* ☐ *Other:*			*GeoAncestry/Ethnicity*
Has patient been tested previously at PreventionGenetics? ☐ Yes ☐ No *If yes, PG ID#:*	*Has patient's relative been tested at PreventionGenetics?* ☐ Yes ☐ No *If yes, provide name & DOB:*	*Related to an ongoing pregnancy?* ☐ Yes ☐ No	*Bone marrow transplant or blood transfusion?* ☐ Yes ☐ No *If yes, date:*

Test Selection

☐	*Chromosomal Microarray only (consent required for CMA)*
☐	*Exome Sequencing only (consent required for PGxome)*
☐	*Chromosomal Microarray with reflex to Exome Sequencing (consent required for CMA & PGxome)*
☐	*Chromosomal Microarray & Exome Sequencing, concurrent (consent required for CMA & PGxome)*

Secondary Findings

The American College of Medical Genetics (ACMG) has recommended secondary findings in a minimum of 56 genes be reported. Pathogenic or likely pathogenic variants in these genes will be reported by default unless a patient desires to "opt-out."

- ☐ *ACMG 56 OPT OUT – PGxome*
- ☐ *ACMG 56 OPT OUT – CMA-ISCA*

Additional secondary findings can be reported if desired should the patient desire to "opt-in."

- ☐ *Additional findings OPT IN – PGxome*
- ☐ *Additional findings OPT IN – CMA-ISCA*

Details can be found in the PGxome and/or CMA-ISCA Healthcare Provider Statement (required).

Additional Family Members (PGxome Only)

For trio testing, please list family members' information. Biological parent samples are required.

Name (Last, First)	*Date of Birth (MM/DD/YY)*	Sample Type	Relationship to proband	Affected?
Name (Last, First)	*Date of Birth (MM/DD/YY)*	Sample Type	Relationship to proband	Affected?
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Clinical Information

Indication for Testing

A copy of a clinic summary/note is required. Other relevant medical records, genetic testing results, and/or other results are encouraged to be included. Please also include a copy of the pedigree with family medical health history.

Clinical information is critical for best interpretation of CMA-ISCA and/or PGxome data.

Primary Indication:

- ☐ Developmental Delay
- ☐ Dysmorphic Features
- ☐ Multiple Congenital Anomalies
- ☐ Neurological
- ☐ Other (provide detail):

Additional Clinical Information

(optional - check all that apply)

Perinatal History
- ☐ Prematurity
- ☐ Intrauterine Growth Restriction (IUGR)
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ Cystic hygroma
- ☐ Increased nuchal translucency (NT)
- ☐ Other

Growth & Development
- ☐ Failure to thrive
- ☐ Overgrowth
- ☐ Short stature
- ☐ Fine motor delay
- ☐ Gross motor delay
- ☐ Other

Cognition & Behavior
- ☐ Speech delay
- ☐ Intellectual disability
  - o Mild
  - o Moderate
  - o Severe
- ☐ Learning disability
- ☐ Autism spectrum disorder
- ☐ ADHD
- ☐ Obsessive-compulsive disorder
- ☐ Other

Musculoskeletal
- ☐ Club foot/feet
- ☐ Contractures
- ☐ Pterygium
- ☐ Diaphragmatic hernia
- ☐ Limb anolamly
- ☐ Polydactyly
- ☐ Syndactyly
- ☐ Scoliosis
- ☐ Kyphosis
- ☐ Vertebral anomaly
- ☐ Other

Skin, Hair, & Nails
- ☐ Hyperpigmentation (describe)
- ☐ Hypopigmentation (describe)
- ☐ Unusual scarring
- ☐ Connective tissue abnormality (describe)
- ☐ Ichthyosis
- ☐ Rash
- ☐ Blistering
- ☐ Lipoma (or other skin tumors)
- ☐ Hair abnormality (describe)
  - o Quality
  - o Quantity
  - o Distribution
  - o Pigmentation
- ☐ Nail abnormality (describe)
  - o Size
  - o Shape
  - o Texture
- ☐ Other

Hematologic & Immunologic
- ☐ Anemia
- ☐ Neutropenia
- ☐ Pancytopenia
- ☐ Immunodeficiency
- ☐ Other

Neurological & Muscular
- ☐ Ataxia
- ☐ Chorea
- ☐ Seizures/Epilepsy
- ☐ Encephalopathy
- ☐ Hypotonia
- ☐ Hypertonia
- ☐ Spasticity
- ☐ Dystonia
- ☐ Muscle weakness/atrophy
- ☐ Exercise intolerance
- ☐ Structural brain abnormalities/abnormal brain imaging (describe)
- ☐ Other

Craniofacial (including hearing & vision)
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Craniosynostosis
- ☐ Dysmorphic features (describe)
- ☐ Ear malformation (describe)
- ☐ Microcephaly
- ☐ Macrocephaly
- ☐ Cataracts
- ☐ Coloboma (of eye)
- ☐ Chronic progressive external ophthalmoplegia
- ☐ Ptosis
- ☐ Abnormal vision (describe)
- ☐ Optic atrophy
- ☐ Retinitis pigmentosa
- ☐ Abnormal eye movement
- ☐ Abnormal hearing (describe)
- ☐ Other

Gastrointestinal
- ☐ Gastroschisis
- ☐ Omphalocele
- ☐ Pyloric stenosis
- ☐ Anal atresia
- ☐ Tracheoesophageal fistula
- ☐ Chronic diarrhea
- ☐ Chronic constipation
- ☐ Gastrointestinal reflux
- ☐ Recurrent vomiting
- ☐ Hirschsprung disease
- ☐ Chronic intestinal pseudo-obstruction
- ☐ Other

Genitourinary
- ☐ Ambiguous genitalia
- ☐ Cryptochidism
- ☐ Hydronephrosis
- ☐ Hypospadias
- ☐ Kidney malformation

Genitourinary (continued)
- ☐ Renal agenesis or dysgenesis
- ☐ Undescended testis
- ☐ Renal tubulopathy
- ☐ Other

Endocrine
- ☐ Diabetes mellitus
  - o Type I
  - o Type II
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hypoparathyroidism
- ☐ Hyperparathyroidism
- ☐ Other

Metabolic
- ☐ Ketosis
- ☐ Lactic acidosis
- ☐ Abnormal urine organic acids (describe)
- ☐ Abnormal plasma amino acids (describe)
- ☐ Abnormal acylcarnitine profile (describe)
- ☐ Abnormal CPK
- ☐ Other

Tumors
- ☐ Tumor (describe)
- ☐ Age of onset
- ☐ Other

Additional Testing (please attach copies of results if available)
- ☐ Chromosomes (karyotype), result :
- ☐ Chromosomal Microarray (CMA), result :

Other molecular studies, results :

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Provider/Laboratory Contact Information

- **Our preferred method of report transmission is email (via ShareFile). Please provide an email address when possible.**
- **If you have additional specific reporting requests, please indicate them below.**

Provider Information			
Institution			
Address (please include city, state, country & postal code)			
Requesting Physician (First, Last, Degree)		***Requesting Genetic Counselor (First, Last, Degree)***	
Phone Number	***NPI#:***	***Phone Number***	***NPI#***
Email		***Email***	
Test Reporting Instructions ***Our preferred method of report transmission is email (via ShareFile)***		**Test Reporting Instructions** ***Our preferred method of report transmission is email (via ShareFile)***	
Email (via ShareFile): ☐ *use above* ☐ ***DO NOT email results. Instead, send via fax (provide fax #):***		***Email (via ShareFile):*** ☐ *use above* ☐ ***DO NOT email results. Instead, send via fax (provide fax #):***	

Sendout Laboratory (Complete only if report needed)	**Other**
Laboratory & Contact Person	***Contact Name***
Address	***Address***
Phone Number	***Phone Number***
Email	***Email***
Test Reporting Instructions ***Our preferred method of report transmission is email (via ShareFile)***	**Test Reporting Instructions** ***Our preferred method of report transmission is email (via ShareFile)***
Email (via ShareFile): ☐ *use above* ☐ ***DO NOT email results. Instead, send via fax (provide fax #):***	***Email (via ShareFile):*** ☐ *use above* ☐ ***DO NOT email results. Instead, send via fax (provide fax #):***

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Billing Instructions

1. Please choose one of the three billing options:

- ☐ Institutional
- ☐ Individual
- ☐ Insurance

2. Provide all information for the selected option only

Note: Patient testing will be delayed until all of the billing requirements have been met. Please print clearly. If Individual/Insurance billing information is incomplete, the Institution will be billed. Tests that are cancelled while in progress will be billed for the amount of work completed up to that point. If the patient's specimen is collected in New York, a New York State Non-Permitted Laboratory Test Request approval letter must be included before testing will proceed.

1. Institutional Billing (Preferred)

Billing Institution		*PO Number*
Contact	*Phone Number(s)*	*Email*
Address		
City	*State*	*Zip*
Email Invoice **Email Address:**	*Copy of Test Report(s) for Billing* ☐ **Email (via ShareFile):** ☐ same as previous ☐ **Other (please specify):**	

2. Individual Billing

Responsible Party's Name (Must be 18 years or older)	*Phone Number(s)*	*Email*
Address		
City	*State*	*Zip*

ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR GENETIC TESTING

Note: PreventionGenetics cannot proceed with testing of the specimen without a signature below.

My signature below indicates that I accept financial responsibility for all fees associated with this genetic testing order.

Signature of Responsible Party	*Printed Name of Responsible Party*	*Date*

COMPLETE THE FOLLOWING FOR CREDIT CARD PAYMENT

Credit Card # / (VISA, Discover, or Mastercard only)	*Expiration Date*	*3-Digit Security Code*

My signature below authorizes PreventionGenetics to charge my credit card for services for which I am responsible.

Signature: ***Date:***

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Billing Instructions

3. Insurance Billing

We will file an insurance claim on behalf of the patient with any commercial insurance company. However, the claim will be submitted as an "out of network" service provider. We are in network (contracted provider) with a limited number of insurance plans (see website). The patient is responsible for any portion of the test fee not covered by the insurance company for any reason including, but not limited to, co-payments, co-insurance, unmet deductibles, or non-covered services.

Responsible Party's Name (Must be 18)	*Phone Number(s)*	*Email*

Responsible Party Address

City *State* *Zip*

Policyholder Name (Required)	*Please indicate the type of insurance: (Circle One)* *Private / Medicare / WI Medicaid*	*Primary Insurance Company Name (Required)*

Insurance Company Address- Claims

City *State* *Zip*

ICD-10 Codes (Required)	*Policy ID#*	*Group #*	*Authorization #*

Please attach the following:

Note: PreventionGenetics cannot proceed with testing of the specimen until all information is received.

- ☐ *NPI # of Requesting Physician* _____
- ☐ *Medicare – signed ABN Form* ***completed IN FULL***
- ☐ *Copy of both sides of Insurance Card*
- ☐ *Authorization number or letter of agreement from insurance company (if available). If not included, we will routinely perform pre-verification prior to initiating testing & will relay information to ordering provider.*
- ☐ *Letter of Medical Necessity*
- ☐ *Relevant Medical Records*
- ☐ *NY Non-permitted lab approval letter (if specimen collected in NY)*

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR MY ACCOUNT

Note: PreventionGenetics cannot proceed with testing of the specimen without a signature below.

I authorize PreventionGenetics to release information received including, without limitation, medical information, which includes laboratory test results, such as genetic tests results, to my health plan/insurance carrier and its authorized representatives. I further authorize insurance payments directly to PreventionGenetics for the services rendered. I understand my health plan/insurance/Medicare/Medicaid carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity or otherwise. I understand I am financially responsible for fees not paid in full by my insurer, co-payments, and policy deductibles except where my liability is limited by contract or State and Federal law. I agree to help PreventionGenetics resolve any insurance claim issues.

_____ _____ _____

Signature of Patient or Guardian *Printed Name of Patient or Guardian* *Date*

Credit Card # / (VISA, Discover, or Mastercard only)	*Expiration Date*	*3- Digit Security Code*

My signature below authorizes PreventionGenetics to charge my credit card for services for which I am responsible upon completion of insurance processing.

Signature: *Date:*

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Specimen and Shipping Instructions

Specimen Requirements

WHOLE BLOOD: Collect 3-5 ml of whole blood in EDTA (purple top tube) or ACD (yellow top tube), minimum 1 ml for small infants.

DNA: Send in screw cap tube at least 10 µg of purified DNA at a concentration of at least 100 µg/ml (indicate concentration on tube label) for exome only.

SALIVA, CELL CULTURE, & FRESH, FROZEN TISSUE: Please contact us.

Shipping/Handling Instructions

Please label all specimen containers with the patient name, date of birth and/or ID number. At least two identifiers should be listed on specimen containers. We accept specimen deliveries Monday-Saturday for all specimen types except cell cultures. Cell culture deliveries are routinely accepted Monday-Thursday and require advance notice of arrival. If a Friday delivery is necessary please contact us to make arrangements. Holiday schedules will be posted on our home page at least one week prior to major holidays.

BLOOD: Do not freeze. During hot weather, include a frozen ice pack in the shipping container. Place a paper towel or other thin material between the ice pack and the blood tube. In cold weather include an unfrozen ice pack in the shipping container as insulation. At room temperature, blood specimen is stable for up to 48 hours. If refrigerated, blood specimen is stable for up to one week.

DNA: DNA may be shipped at room temperature. Label the tube with the composition of the solute, DNA concentration as well as the patient name, date of birth, and/or ID number. We only accept genomic DNA for testing. We do NOT accept products of whole genome amplification reactions or other amplification reactions.

CELL CULTURES: We are NOT able to culture cells. Send confluent flasks of cultured cells in insulated, shatterproof container overnight.

Address	Testing Kits
Diagnostic Lab PreventionGenetics 3800 S. Business Park Ave. Marshfield, WI 54449 USA	Clinical testing kits with prepaid return shipping are now available for our U.S. clients. We are able to provide Clinical Testing Kits to our international clients without the return postage at this time. To order kits, submit requests through our Electronic Order Form or contact our Client Service Representatives at 715-387-0484, ext. 0.

DNA Genotyping Panel

For quality control purposes, the PreventionGenetics DNA Genotyping Panel is performed on all clinical specimens. Genotyping results are ***not*** included in test reports.

DNA Banking

DNA Banking has a reduced price of $98 for patients if clinical testing is also being performed with us. For DNA Banking, see our DNA Banking Process and DNA Banking Forms. For questions related to DNA Banking, contact our DNA Banking Director at 715-387-0484, ext. 151 or email dnabanking@preventiongenetics.com.

Contact Us

For additional questions or concerns, please contact our Client Service Representatives at 715-387-0484, ext. 0 or our Genetic Counseling Team at ext. 208 or clinicaldnatesting@preventiongenetics.com.