PREVENTION GENETICS

DISEASE PREVENTION THROUGH GENETIC TESTING

PREVENTIONGENETICS USE ONLY

Test information is available on our website:
www.PreventionGenetics.com

All testing must be ordered by a qualified Healthcare Provider

THIS FORM MUST ACCOMPANY ALL SPECIMENS

STANDARD TEST REQUISITION FORM

PERSON COMPLETING FORM	CONTACT (PHONE OR EMAIL)	DATE OF REQUEST
		____ / ____ / ____ MONTH / DAY / YEAR

PATIENT INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH
			____ / ____ / ____ MONTH / DAY / YEAR

PATIENT ID	SPECIMEN COLLECTION DATE	SEX
	MONTH ____ / DAY ____ / YEAR ____	☐ Male ☐ Female ☐ Other

SPECIMEN SOURCE

☐ Whole Blood ☐ Extracted DNA, Source ____ ☐ Saliva
☐ Direct Amniotic Fluid ☐ Cultured Cells, Source ____ ☐ Other ____
☐ Direct CVS ☐ Tissue, Source ____

REASON FOR TEST

☐ Diagnosis / Affected
☐ Presymptomatic / At Risk
☐ Carrier Testing

SPECIFY KARYOTYPE

GEOANCESTRY / ETHNICITY

HAS PATIENT BEEN TESTED PREVIOUSLY AT PreventionGenetics?

☐ NO ☐ YES, PG ID# ____

HAS PATIENT'S RELATIVE BEEN TESTED PREVIOUSLY AT PreventionGenetics?

☐ NO ☐ YES
Name and DOB or PG ID# ____

BLOOD TRANSFUSION

☐ NO
☐ Within Last 30 Days, Date and Type
____ / ____ / ____ MONTH / DAY / YEAR
TYPE ____

BONE MARROW TRANSPLANT

☐ NO
☐ YES
____ / ____ / ____ MONTH / DAY / YEAR

ONGOING PREGNANCY

☐ NO
☐ YES
Prenatal Healthcare Statement required for fetal testing of ongoing pregnancies.

OTHER RELEVANT CLINICAL INFORMATION (Labs, biopsies, other genetic testing performed, etc.) ***PLEASE ATTACH PEDIGREE, IF POSSIBLE.***

TEST SELECTION

List below the tests to be performed. Test Codes, Test Names and Turnaround Times (TAT) are available at www.PreventionGenetics.com. Include any special test instructions in the comments section. The tests will be performed in the order listed unless otherwise specified. Unless specifically requested, we will run Sanger panels sequentially based on sensitivity.
**We offer a STAT option below for Sanger sequencing and gene-centric aCGH. The majority of STAT tests are completed within 8-10 calendar days. If we are unable to complete STAT requests within 10 days, surcharge will be waived. NextGen panels are not currently available to be ordered STAT.

	TEST CODE	TEST NAME
TEST ORDER 1		
TEST ORDER 2		
TEST ORDER 3		
TEST ORDER 4		

COMMENTS:

SPECIAL INSTRUCTIONS

☐ **CONCURRENT TESTING**
All tests and genes ordered to be run simultaneously.

☐ **STAT TESTING****
For STAT add 25% to price. Tests ordered will be run concurrently unless otherwise instructed.

☐ **HOLD TESTING**
Pending MOH approval, insurance pre-authorization, etc.

☐ **SPECIMEN COLLECTED IN NEW YORK STATE**
Include New York State Non-Permitted Laboratory Test Request approval letter if test is not NY state approved and Genetic Testing Healthcare Provider Statement. For a list of tests that are NY state approved see website.

☐ **POSITIVE CONTROL ONLY**
No charge / No report

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PROVIDER / LABORATORY CONTACT INFORMATION

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

PROVIDER INFORMATION

INSTITUTION

ADDRESS (City, State, Country and Postal Code)

REQUESTING PHYSICIAN (First, Last, Degree)		**REQUESTING GENETIC COUNSELOR OR ALLIED PROVIDER (First, Last, Degree)**	
PHONE NUMBER	**NPI#**	**PHONE NUMBER**	**NPI#**
EMAIL		**EMAIL**	

TEST REPORTING INSTRUCTIONS
Our preferred method of report transmission is email via ZixCorp

SECURE EMAIL VIA ZIXCORP ☐ *Use above email address*

☐ DO NOT USE ZIXCORP. EMAIL RESULTS VIA SHAREFILE.
☐ DO NOT EMAIL RESULTS. Send via fax (provide fax number):

(_____) _____-_____

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(_____) _____-_____

SENDOUT LABORATORY COMPLETE ONLY IF REPORT IS NEEDED

INSTITUTION / CONTACT

ADDRESS (City, State, Country and Postal Code)

PHONE NUMBER	**NPI# (Where Applicable)**
EMAIL	

TEST REPORTING INSTRUCTIONS
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(_____) _____-_____

OTHER

INSTITUTION / CONTACT

ADDRESS (City, State, Country and Postal Code)

PHONE NUMBER	**NPI# (Where Applicable)**
EMAIL	

TEST REPORTING INSTRUCTIONS
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(_____) _____-_____

As the ordering Healthcare Provider, I confirm I have obtained the patient's informed consent, either verbally or in writing, to perform this test. I further confirm the patient has been appropriately counseled and understands the risks, benefits, and limitations of this genetic testing and the implications of the results.

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BILLING - PLEASE SELECT INSTITUTIONAL OR SELF-PAY WITH OPTION TO SUBMIT TO INSURANCE

PATIENT TESTING WILL BE DELAYED UNTIL ALL OF THE BILLING REQUIREMENTS HAVE BEEN MET. PLEASE PRINT CLEARLY.

If the patient's specimen is collected in New York, a New York State Non-Permitted Laboratory Test Request approval letter (where applicable) and Genetic Testing Healthcare Provider Statement (see website) must be included before testing will proceed.

INSTITUTIONAL BILLING

BILLING INSTITUTION		PO NUMBER	
CONTACT	PHONE NUMBER	EMAIL	
ADDRESS	CITY	STATE	ZIP
BILLING ACCOUNT NUMBER ☐ UPDATED INFO		COPY OF TEST REPORT(S) FOR BILLING	
EMAIL INVOICE VIA ZIXCORP (PROVIDE EMAIL ADDRESS)		☐ EMAIL (VIA ZIXCORP) _____	
		☐ OTHER (PLEASE SPECIFY) _____	

SELF-PAY **THIS SECTION MUST BE FILLED OUT COMPLETELY**

RESPONSIBLE PARTY'S NAME *(MUST BE 18 YEARS OR OLDER)*	PHONE NUMBER	EMAIL	
ADDRESS	CITY	STATE	ZIP

ACCEPTANCE of financial responsibility for genetic testing ***PREVENTIONGENETICS CANNOT PROCEED WITH TESTING OF THE SPECIMEN WITHOUT A SIGNATURE BELOW.***

My signature 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 NUMBER (VISA, DISCOVER, OR MASTERCARD ONLY)	EXPIRATION DATE	3-DIGIT SECURITY CODE

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

SIGNATURE _____ DATE _____

☐ SUBMIT CLAIM TO INSURANCE (OPTIONAL)

POLICYHOLDER'S NAME (REQUIRED)		PLEASE INDICATE THE TYPE OF INSURANCE ☐ PRIVATE ☐ MEDICARE ☐ WI MEDICAID *We only accept WI Medicaid*	
PRIMARY INSURANCE COMPANY NAME (REQUIRED)		☐ *ATTACH A COPY OF INSURANCE CARD both sides*	
INSURANCE COMPANY ADDRESS - CLAIMS	CITY	STATE	ZIP
ICD-10 CODES (REQUIRED)	POLICY ID#	GROUP #	AUTHORIZATION #

PLEASE ATTACH THE FOLLOWING DOCUMENTATION *PreventionGenetics cannot proceed with testing of the specimen until all information is received.*

☐ NPI # of Requesting Physician _____

☐ *MEDICARE – signed ABN Form completed IN FULL*

☐ *AUTHORIZATION NUMBER* or letter of agreement from Insurance Company (if available). If not included, we will routinely perform pre-verification prior to initiating testing and will relay information to ordering provider.

☐ *Relevant Medical Records addressing medical necessity and/or Letter of Medical Necessity*

☐ ***SHARE RESULTS*** of benefits investigation with patient directly via email provided above

or FAX # (_____) _____-_____

AUTHORIZATION to assign benefits and accept financial responsibility for my account

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

☐ Proceed with testing once all required information has been sent, *regardless of benefit investigation* (to avoid testing being placed ON HOLD pending pre-authorization, if needed). Option does NOT apply for Medicaid.

SIGNATURE OF RESPONSIBLE PARTY _____ PRINTED NAME OF RESPONSIBLE PARTY _____ DATE _____

SPECIMEN REQUIREMENTS AND TURNAROUND TIMES (TAT)

PREVENTIONGENETICS PREFERRED SPECIMEN TYPES

PLEASE CONTACT US WITH ADDITIONAL SPECIMEN REQUIREMENT QUESTIONS.

STAT TAT (8-10 calendar days) available at a 25% surcharge for Sanger Sequencing and aCGH. Cannot be guaranteed for aCGH.

WHOLE BLOOD

Collect 3 ml - 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 5 µg -10 µg of purified DNA at a concentration of at least 20 ng/µL for NGS and Sanger tests and at least 5 µg of purified DNA at a concentration of at least 100 ng/µL for gene-centric aCGH, MLPA, and CMA tests, minimum 2 µg for limited specimens. Indicate concentration on tube label. For requests requiring more than one test, send an additional 5 µg DNA per test ordered when possible.

SALIVA

Oragene™ Saliva Collection kit used according to manufacturer instructions.

FETAL (CVS/AMNIOCYTES) AND OTHER CELL CULTURES

Culture and send at least two, T25 flasks of confluent cells. For sequencing or gene-centric aCGH panels, two flasks are often sufficient; however, some panels may require additional flasks (dependent on size of genes, amount of Sanger sequencing required, etc.). Multiple test requests may also require additional flasks. Please contact us for details. We strongly recommend maintaining a back-up culture.

Fetal cell cultures are available at PreventionGenetics from direct amniotic fluid, chorionic villi, or products of conception (POC) via Test Code #995 (cost $250). Collect 10 ml - 20 ml of direct amniotic fluid or 5 mg - 10 mg cleaned CVS tissue (~15-20 cleaned villi) or 2mm x 2mm x 2mm fresh tissue. CPT code 88235 for amniotic fluid/chorionic villi or 88233 for POC specimens.

	TEST METHOD	WHOLE BLOOD	DNA	SALIVA	CELL CULTURES	FRESH, FROZEN TISSUE	BUCCAL SWABS	DIRECT AMNIOTIC FLUID/CVS	OTHER	TURN AROUND TIME (TAT)
SEQUENCING	NextGen (NGS)	★	★	★	★	★	■	■ C	–	28 days
	PGxome™/ PGxome Custom Panels	★	★ B	★	★ B	★	–	–	–	6 weeks
	Sanger	★	★	★	★	★	■	■ C	Semen D	18 days
DEL / DUP	Gene-centric aCGH	★	★	■	■	★	–	■ C	–	28 days
	MLPA	★	★ A	ONLY TEST #1941	★ A	–	–	–	–	20 days
	Chromosomal Microarray (CMA)	★	★	■	★	★	–	■	–	20 days

EXCEPTIONS

A - Cell cultures and DNA extracted from CVS and amniocytes not accepted for MLPA; DNA extracted from saliva (except test #1941) also not accepted.

B - Cell cultures and DNA extracted from CVS and amniocytes acceptable for PGxome for non-ongoing pregnancies only.

C - Direct prenatal specimen types most appropriate for targeted prenatal familial variant testing (Test Code #990), and strongly discouraged for full gene and panel tests. Back-up culture highly recommended.

D - Semen: Collect 1-2 vials and flash freeze. Vials to be sent frozen (preferably on dry ice). Contact us for details.

KEY

★ PREFERRED

■ ACCEPTED

– NOT ACCEPTED

FRESH, FROZEN TISSUE

Collect 2mm x 2mm x 2mm tissue and flash freeze. Tissue to be sent frozen (preferably dry ice). Contact us for additional details.

BUCCAL SWABS

Buccal swabs are most appropriate for targeted, known variant testing. Collect 3-6 buccal swabs for targeted, known variant testing and 10-20 buccal swabs for sequencing of full gene(s).

DIRECT AMNIOTIC FLUID/CHORIONIC VILLI

Collect 10 ml -20 ml of direct amniotic fluid or 5 mg -10 mg cleaned CVS tissue (~15-20 cleaned villi). We strongly recommend maintaining a local back-up culture. Fetal cell cultures available (Test Code #995, $250).

SHIPPING & HANDLING INSTRUCTIONS

Please label all specimen containers with the patient's 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, direct amniotic fluid, or direct chorionic villi. Cell culture deliveries are routinely accepted Monday-Thursday and require advance notice of arrival. If a Friday or Saturday delivery is necessary, please contact us to make arrangements. Saturday delivery should especially be avoided when possible as prenatal specimens are not processed over the weekend. 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's 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, DIRECT AF/CVS, AND POC

Send specimens overnight in an insulated, shatterproof container. Direct AF/CVS or POC specimens can be sent in saline or culture media at room temperature for culturing at PreventionGenetics (Test Code #995, $250).

ADDRESS

Diagnostic Lab
PreventionGenetics
3800 S. Business Park Ave.
Marshfield, WI 54449
USA

TESTING KITS

Clinical testing kits with prepaid return shipping are available for U.S. Clients. We are able to provide clinical testing kits to International clients without the return postage. To order test kits, submit requests through our electronic order form (see website) or contact our Client Service Representatives at (715) 387-0484, ext. 0.

PRENATAL TESTING

Please sign Prenatal Healthcare Provider's Statement for ongoing pregnancies and contact us in advance regarding prenatal test requests. When possible, ship prenatal samples to arrive at PreventionGenetics no later than Thursday.

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 at PreventionGenetics. Visit our website at www.PGDNABank.com for information about the process and forms. For questions related to PGDNABanking, 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 option 2, or email: clinicaldnatesting@preventiongenetics.com.