PREVENTION GENETICS

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

PGxome® - WHOLE EXOME SEQUENCING - HEALTH SCREEN
HEALTHCARE PROVIDER STATEMENT

This statement is required and applies to Whole Exome Sequencing Tests for carrier and/or predisposition.

PATIENT INFORMATION

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

The following information should be used as a guide to provide informed consent to the patient. We require the consenting Healthcare Provider sign below. Testing must be ordered by a qualified Healthcare Provider.

PURPOSE

- The purpose of this test is to provide pan-ethnic carrier screening for autosomal recessive disorders or X-linked recessive disorders (in females) using a Whole Exome Sequencing (WES) test. In addition, patients have the option of also receiving genetic variants that predispose to autosomal or X-linked dominant disorders or X-linked recessive disorders (in males), as well as genetic variants that influence response to certain prescription medications.

ABOUT PGXOME TEST

- This test involves the sequencing of thousands of genes at the same time, whereas many other genetic tests look at only one gene or a small group of genes. The way we perform the exome test is through a procedure called Next Generation Sequencing (NGS). We confirm important results with another type of sequencing called Sanger sequencing. Copy number variants (CNVs), also known as deletions/duplications, are also detected from NGS data. All reported CNVs are confirmed using another technology such as aCGH, MLPA, or PCR.
- We will need about one teaspoon of blood (3-5 ml of whole blood or DNA extracted from such a blood specimen) from the patient to perform testing.
- Results of the test will be presented in an individualized, written report transmitted to the patient's Healthcare Provider(s).
- In accordance with current professional guidelines (Borry et al. 2006. Eur J Hum Genet 14(2):133-8; NSGC Position Statement 2012; Ross et al. 2013 Genet Med 15(3):234-245), we do *NOT* recommend carrier testing for minors (under the age of 18 years). For minors, we recommend carrier testing be postponed until the age of 18 years. In rare cases, we will consider special requests for PGxome carrier testing of minors.
- For additional information about this test, see the PGxome Health Screen test description on the PreventionGenetics website: https://www.preventiongenetics.com/ClinicalTesting/TestCategory/PGxome.php.

REPORT INFORMATION

- Genetic variants are defined as the differences between the patient's DNA and the human reference DNA. We will report all Pathogenic and Likely Pathogenic recessive sequence variants (Richards et al. 2015 Genet Med 17:405-424) within genes currently known to be clinically relevant for carrier status in autosomal recessive disorders or X-linked recessive disorders (in females). Variants in genes not currently known to be clinically relevant will not be reported.
- Some individuals may have two Pathogenic or Likely Pathogenic genetic variants (compound heterozygous or homozygous) in a gene that causes an autosomal recessive disorder. Even if the patient may not be obviously affected by the disorder, this finding could lead to a diagnosis. If we identify this, we will include it in the patient's test report as it also indicates a positive carrier status.
- The patient will very likely have many recessive Variants of Uncertain Significance. We will retain lists of these uncertain variants at PreventionGenetics, but will not include them in the test report.
- We may report other findings (aka "Secondary Findings" - see below) depending on the patient's preference. These Secondary Findings may have an important impact on health, and are provided in the report if the patient opts in (see bottom of first page of Test Requisition Form).
- New research results are continually improving our ability to interpret the WES results. An ordering Healthcare Provider can request a reinterpretation from us.

ISSUING THE REPORT

- Results will be sent directly to the ordering Healthcare Provider(s) and NOT to the patient.
- We recommend genetic counseling and/or clinical genetics consultation before and after testing is completed.
- Patients have the right to receive a copy of their test report. They may obtain a copy from their Healthcare Provider(s) or if a signed patient authorization form (available upon request) is received, from PreventionGenetics.

SECONDARY FINDINGS

- In many patients, WES will reveal one or more additional genetic variants which could be important to the patient's health. These include for example variants predisposing the patient to cancer or heart disease and variants which may inform drug prescription. These are termed secondary findings. The patient may or may not wish to be informed of secondary findings.
- The patient will have a choice about which secondary findings are reported (see bottom of first page of Test Requisition Form). *Please consider the following carefully.* **Variants described in these sections will only be reported if the patient OPTS IN.**
  - The American College of Medical Genetics and Genomics recommends that all labs performing WES report pathogenic variants in 59 genes that cause certain, mostly dominantly inherited disorders (Kalia et al. 2016. Genet Med. Advance online publication. doi:10.1038/gim.2016.190). These disorders are treatable and/or preventable. Included on this list are some cancer predisposition conditions, heart conditions associated with sudden death, and conditions that could result in severe health consequences if surgery is performed with certain anesthetics.
  - Genes involved in other inherited disorders are not included on the ACMG list of 59 genes because it is not as clear if treatment or prevention will be effective (examples: Amendola et al. 2015. Genome Res 25(3):305- 315; Dorschner et al. 2013. Am J Hum Genet 93(4):631-640). Some of these disorders are very serious, leading to death. Some people may want to know about these disorders while others may prefer not to know. Many of these conditions have adult onset, and in accordance with current professional guidelines (Borry et al. 2006 Clin Genet 70(5):374-81; Lucassen et al. 2010 British Society for Human Genetics;

Fallat et al. 2013 Pediatrics 131(3): 620–2; NSGC Position Statement 2017), we do not recommend testing for adult onset conditions in minors (under the age of 18 years). For minors, we recommend that this testing be postponed until the age of 18 years or that access to this portion of their healthcare records be blocked until they reach 18 years.

- Pharmacogenetic variants are those that influence an individual's response to certain prescription medications. A healthcare provider considering prescribing one of these medications may adjust dosage or choose an alternate medication dependent on the presence of certain pharmacogenetic variants. PreventionGenetics has selected 15 genes known to influence prescription drug response to include in our PGxome based on evidence supporting gene-drug interactions (https://www.pharmgkb.org). For a full gene list, please see the PGxome test description on our website. Although less likely, rare variants in these genes may be identified that confer risk for a Mendelian disease or carrier status. The pharmacogenetics section of the report will only include variants associated with drug response.

- Genetic variants related to complex disease, and mitochondrial disorders (excluding nuclear genes) will not be reported at this time.
- Genetic variants in genes not currently known to be involved in human disease will not be reported.

DATA

- PreventionGenetics will store the patient's sequence data. This will permit reanalysis and reinterpretation of the data in the future. Upon Physician's request, PreventionGenetics will perform, without additional charge, one reanalysis and reinterpretation of the data within three years of the date on the original test report. Thereafter, reanalysis and reinterpretation may be requested, but a fee will be charged for this service.
- PreventionGenetics recommends DNA sequence information from this test be stored in the patient's electronic medical record. This will best benefit the patient and family members. Upon request, PreventionGenetics will provide WES data such as a list of sequence variants, a list of genes analyzed, and .bed files with coverage information. PreventionGenetics does not supply software for data review and interpretation.

RISKS

- Blood draw risks include bruising and bleeding. There is also a small chance you may get an infection, have excess bleeding, become dizzy, or faint from the blood draw.
- Learning about test results can be stressful and upsetting.
- The patient and/or patient's family may have concerns about genetic discrimination, including health insurance, life insurance, employment and long-term disability. These should be addressed according to federal and state laws. The Federal Genetic Information Non-discrimination Act (GINA) prohibits the use of genetic information for discrimination in health insurance and employment.

LIMITATIONS

- This test targets most, but not all, of the coding parts of our genes (called exons). All of the exons together is called the exome. The exome only covers approximately 1.5% of all the genetic material. However, testing the exome covers the vast majority of genetic variants which cause single gene (or Mendelian) disorders.
- Interpretation of the test results is limited by the information currently available. Better interpretation could be possible in the future as more data and knowledge about human genetics are accumulated.
- Testing will detect single base pair changes and small and large deletions or duplications, but we are generally not able to detect other types of genetic changes (e.g. rearrangements, inversions, deep intronic variants, methylation abnormalities, or repetitive sequence changes).
- This test will not provide detection of certain genes or specific exons of genes due to complicated technicalities (such as sequence characteristics, interfering pseudogenes, or inadequate coverage). In the case of deletions/duplications, most will be detected including intragenic CNVs and large cytogenetic events. CNVs of 4 exons or more in size are detected with sensitivity approaching 100% through analysis of NGS data. However, sensitivity for detection of CNVs smaller than 4 exons is lower (we estimate ~75%). Sensitivity may vary from gene-to-gene based on exon size, depth of coverage, and characteristics of the region. *Because of these technicalities, this test is not 100% sensitive and will not identify all disease-causing genetic variants.*
- Even if a disease-causing genetic variant associated with a positive carrier status is identified in the patient, it may not allow for accurate predictions regarding severity of the disease or prognosis for future children.
- Additional limitations to this test will be provided in the Supplementary material included with the test report.

CONFIDENTIALITY

- We take confidentiality and patient privacy very seriously. We follow confidentiality laws related to protected health information and are a CAP and CLIA certified laboratory.

TURNAROUND TIME (TAT)

- The maximum TAT for our PGxome® test is 45 days.

I have provided informed consent to my patient. My patient has had the opportunity to ask questions. Please indicate patient preferences for Secondary Findings on the PGxome Health Screen Test Requisition Form.

HEALTHCARE PROVIDER SIGNATURE _____ PRINTED NAME _____ DATE _____

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PGxome® HEALTH SCREEN
TEST REQUISITION FORM

- The primary purpose of this test is for carrier and disease susceptibility screening. For diagnostic purposes, use our Diagnostic PGxome Test Requisition Form.
- Test information is available at www.PreventionGenetics.com.
- Testing must be ordered by a qualified Healthcare Provider.

ORDERING CHECKLIST (required)
- ☐ Patient specimen
- ☐ Healthcare Provider Statement
- ☐ Relevant medical records and family health history information (i.e. clinic notes, prior genetic testing, pedigree)

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
- ☐ Direct Amniotic Fluid
- ☐ Direct CVS
- ☐ Extracted DNA, Source _____
- ☐ Cultured Cells, Source _____
- ☐ Tissue, Source _____
- ☐ Saliva
- ☐ Other _____

REASON FOR TEST
- ☐ Diagnosis / Affected
- ☐ Presymptomatic / At Risk
- ☐ Carrier Testing

_____ SPECIFY KARYOTYPE

GEOANCESTRY / ETHNICITY

AS 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

TESTING RELATED TO AND ONGOING PREGNANCY
☐ NO ☐ YES
Prenatal Healthcare Statement required for fetal testing of ongoing pregnancies.

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

TEST SELECTION

☐ Test Code 4000

PGxome® Health Screen

☐ SINGLETON

☐ COUPLE
Complete a separate PGxome Health Screen Form for each individual

Partner's Name _____

DOB _____

☐ ADDITIONAL FAMILY MEMBER REPORT
As part of PGxome Diagnostic family testing

Proband's Name _____

DOB _____

Secondary (Additional) Findings

Testing may reveal other genetic information unrelated to carrier testing. These are termed Secondary Findings. **Details can be found in the PGxome Health Screen Provider Statement (required). Options for reporting of Secondary Findings are to be marked below. If left blank, only carrier status will be reported.**

☐ OPT IN: ACMG 59 GENES

☐ OPT IN: OTHER PREDISPOSITIONS / DIAGNOSES

☐ OPT IN: PHARMACOGENETIC VARIANTS

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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):

(_____) _____-_____

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

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

(_____) _____-_____

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
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):

(_____) _____-_____

OTHER

INSTITUTION / CONTACT

ADDRESS (City, State, Country and Postal Code)

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

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

SECURE EMAIL VIA ZIXCORP ☐ *Use above email address*

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☐ DO NOT EMAIL RESULTS. Send via fax (provide fax number):

(_____) _____-_____

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.

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

PREFERRED SPECIMEN REQUIREMENTS AND TURNAROUND TIMES (TAT)

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™ or GeneFiX™ 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 SWAB	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 SWAB

ORAcollect•Dx (OCD-100) collection kit used according to manufacturer instructions. Buccal swabs are most appropriate for targeted, known variant testing.

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 AND 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).

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.

ADDRESS

PreventionGenetics - Diagnostic Lab
3800 S. Business Park Ave.
Marshfield, Wisconsin 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.