

MOLECULAR GENETICS LABORATORY TEST REQUISITION 411-003G front / 01-11

PATIENT / SPECIMEN INFORMATION

PATIENT NAME - LAST, FIRST, MI		<input type="checkbox"/> M <input type="checkbox"/> F	SSN OR MRN	DATE OF BIRTH
RACE	DIAGNOSIS - INDICATIONS FOR TESTING			
ICD9	SPECIMEN TYPE	COLLECTION DATE	TIME	CONSENT OBTAINED <input type="checkbox"/> Yes <input type="checkbox"/> No

REFERRAL SOURCE

REQUESTING / CONTACT PHYSICIAN	REQUESTING PHYSICIAN / PRACTITIONER SIGNATURE - (REQUIRED BY MEDICARE)		
PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE	PHONE NUMBER	FAX RESULTS	FAX NUMBER <input type="checkbox"/> No <input type="checkbox"/> Yes
REFERRING FACILITY			
FACILITY ADDRESS, CITY, STATE, ZIP - IF DIFFERENT FROM ABOVE	PHONE NUMBER	FAX RESULTS	FAX NUMBER <input type="checkbox"/> No <input type="checkbox"/> Yes
ADDITIONAL REPORTS TO			

MOLECULAR GENETICS TESTS

Achondroplasia (FGFR3)	Hearing Loss - Mitochondrial Mutation A1555G	Pfeiffer Syndrome (only FGFR1 - P252R)
Alagille Syndrome (JAG1) - RNA ⁵	Hearing Loss - Mitochondrial Panel (mtA1555G & MTTTS-1)	Pick Disease (FTDP) - exon 10 only
Alagille Syndrome (JAG1) - DNA ⁵	Hearing Loss - MTTTS1	Pick Disease (MAPT Complete gene)
Albright Hereditary Osteodystrophy (GNAS1)	Hearing Loss - Pendred Syndrome (SLC26A4)	Polycystic Kidney Disease (PKD1 Linkage) ²
ALS (Lou Gehrig's Disease; SOD1)	Hearing Loss - Waardenberg, type 1 & 3 (PAX3)	Polycystic Kidney Disease (PKD2 Linkage) ²
Androgen Insensitivity Syndrome	Hearing Loss - Waardenberg, type 2 (MITF)	Prader-Willi Syndrome (Methylation)
Angelman Syndrome (Methylation)	Hearing Loss - Waardenburg Syndrome panel (PAX3 & MITF)	Prader-Willi Syndrome (UPD) ⁵
Angelman Syndrome (UPD) ⁵	Hemochromatosis	Prothrombin
Apert's Syndrome (FGFR2)	Huntington Disease (HD) ⁴	Pseudohypoparathyroidism (GNAS1)
Beckwith-Wiedemann Syndrome (UPD) ⁵	Hypochondroplasia (FGFR3)	Saethre-Chotzen Syndrome (TWIST)
Blau Syndrome (NOD2/CARD15 Complete Gene)	Hypotonia Panel (DM, PWS, SMA) ³	SOD1 (ALS, Lou Gehrig's Disease)
Congenital Adrenal Hyperplasia ⁶ (21-hydroxylase deficiency)	JAK2 (V617F)	Spinal & Bulbar Muscular Atrophy (SBMA; Kennedy Disease)
Connexin 26 gene	K-ras ⁵ (codons 12 and 13)	Spinal Muscular Atrophy, Types 1, 2, & 3 (SMA)
Connexin 30 gene	Li-Fraumeni Syndrome (p53) ⁵	Spinocerebellar Ataxia, Type 2 (SCA2)
Craniodysmorphism Screen (FGFR 1, 2, & 3)	Marfan Syndrome - unknown mutation - RNA ⁵ (FBN1)	Spinocerebellar Ataxia, Type 3 (SCA3; MJD)
Craniodysmorphism Panel (FGFR TWIST) ³	Marfan Syndrome - unknown mutation - DNA (FBN1)	Spinocerebellar Ataxia, Type 6 (SCA6)
Crohn's Disease (NOD2/CARD15 Complete Gene)	Marfan Syndrome - known mutation (FBN1)	Spinocerebellar Ataxia, Type 7 (SCA7)
Crohn's Disease (NOD2 susceptibility markers)	Marfan Syndrome Neonatal exons (FBN1)	Spinocerebellar Ataxia Panel (SCA1, 2, 3, 6, & 7) ³
Crouzon Syndrome with Acanthosis Nigricans	Marfan Syndrome - Linkage ² (FBN1)	Thyroid Hormone Receptor β
Cystic Fibrosis	Marfan Syndrome, Type 2 - TGFB1 gene	Uniparental Disomy ⁵ (Locus)
DRPLA	Marfan Syndrome, Type 2 - TGFB2 gene	Waardenberg Syndrome Panel (PAX3 & MITF)
Dwarfism Panel ³ (Achondroplasia & Hypochondroplasia)	Marfan Syndrome, Type 2 Panel (TGFB1 and TGFB2)	Waardenberg Syndrome, type 1 & 3 (PAX3)
Dystonia (DYT1)	Maternal Cell Contamination ⁷	Waardenberg Syndrome, type 2 (MITF)
EGFR Mutation Analysis ⁵	MCAD	Warfarin Sensitivity Genotyping (CYP2C9 and VKORC1)
Factor V Leiden	McCune - Albright Syndrome ⁵	X-inactivation
Familial Adenomatous Polyposis (Linkage) ²	MELAS (mt A3243G)	Other:
FGFR (FGFR1, 2, & 3)	MERRF (mt A8344G)	OTHER SERVICES
FGFR2 Gene (Reflex from Craniodysmorphism Tests)	Mitochondrial Panel (MELAS, MERRF, & NARP) ³	Linkage - known allele (include report)
FGFR (FGFR1, 2, 3, & TWIST) ³	Mitochondrial Hearing Loss - mt A1555G	Nucleic Acid Extraction
Fragile X Syndrome	Mitochondrial Hearing Loss - MTTTS1	Sequencing - known mutation (include report)
Friedreich's Ataxia (FRDA)	MTHFR	Tier Testing
FTDP (Pick Disease; Tauopathy; MAPT) - exon 10 only	Muenke Syndrome (only FGFR3 - P250R)	
FTDP (MAPT Complete gene)	Myotonic Dystrophy	
Frontotemporal Dementia (FTD) panel (GRN and MAPT)	NARP & Leigh Syndrome (mt T8993G)	
GNAS1 gene (AHO, PHP1a)	Neurological Panel (HD, SCA, FRDA, DRPLA) ³	² Cannot be performed on a specimen from a single patient. Family Study, Pedigree REQUIRED
GRN gene (PGRN, Granulin)	NOD2/CARD15 gene (Crohn's Disease) (4 Markers)	³ Discounted Panel of Tests
Hearing Loss (Connexin26)	NOD2/CARD15 Complete Gene Analysis	⁴ Consent form MUST accompany specimen (Pre-Symptomatic Patient)
Hearing Loss (Connexin30)	Nonsyndromic Craniodysmorphism (Muenke Syndrome)	⁵ Special Instructions : Please Call Laboratory
Hearing Loss - CX Panel (CX26 & CX30) ³	P53 (Li Fraumeni Syndrome)	⁶ Testing of Parents is STRONGLY recommended when testing prenatal samples
Hearing Loss - Full Panel (CX26&30, mt1555) ³	Pendred Syndrome (SLC26A4A)	⁷ REQUIRED for all prenatal testing

CENTER FOR GENETIC TESTING AT SAINT FRANCIS USE ONLY

DATE RECEIVED	TIME	TYPE / AMOUNT RECEIVED	ACCESSION NUMBER
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Saint Francis Health System Center for Genetic Testing at Saint Francis

Saint Francis Laboratory • 6161 South Yale Avenue • Tulsa, OK 74136
 (918) 502-1720 Phone • (918) 502-1723 Fax • (866) 846-0315 Toll Free
 www.saintfrancisgenetics.com

BILLING INFORMATION 411-003G back / 01-11

PAYMENT INFORMATION - INDICATE ONE

SELF PAY (Payment in Full from Patient or Guarantor)

Check or Money Order

<input type="checkbox"/> Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> MC <input type="checkbox"/> OTHER			CARDHOLDER NAME - PRINT	ZIP CODE
ACCOUNT NUMBER	EXPIRATION DATE	SECURITY NO.	CARDHOLDER - SIGNATURE	

Payment for Medical Care: It is understood and agreed that the undersigned or a designated agent will be responsible and assume an obligation to pay the Center for Genetic Testing at Saint Francis all costs for genetic evaluation and testing rendered to the person whose name appears within thirty (30) days after having been notified of the amount due and owing or will work out a satisfactory payment plan with the Center for Genetic Testing at Saint Francis. It is further understood and agreed that the undersigned or designated agent will, at all times, remain responsible for the costs of said genetic evaluation and testing.

PATIENT SIGNATURE - MUST BE 18 YEARS OR OLDER TO SIGN _____ DATE _____

PARENT / LEGAL GUARDIAN - REQUIRED IF PATIENT IS LESS THAN 18 YEARS OF AGE OR IS NOT LEGALLY COMPETENT _____

ADDRESS, CITY, STATE, ZIP _____ HOME PHONE NUMBER _____

EMPLOYER _____ WORK PHONE NUMBER _____

WITNESS - SIGNATURE _____ DATE _____

INSURANCE (Filed as Courtesy - Patient Ultimately Responsible for Balance of Account)
FRONT AND BACK COPY OF CARD, REFERRAL NUMBER (HMO), REFERRAL DATE AND AUTHORIZATION REQUIRED FOR THIRD PARTY BILLING

INSURED NAME	INSURED SOCIAL SECURITY NUMBER	INSURED DATE OF BIRTH	
PRIMARY CARE PHYSICIAN	EMPLOYER		
INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE	POLICY NUMBER	GROUP NUMBER
INSURANCE COMPANY ADDRESS, CITY, STATE, ZIP CODE			
REFERRAL NUMBER	REFERRAL DATE	EFFECTIVE DATE	AUTHORIZATION NUMBER
MEDICARE NUMBER	MEDICAID NUMBER (OKLAHOMA ONLY)		

Authorization to Release Protected Health Information, Assign Benefits, and Accept Responsibility for My Account: I authorize any physician or laboratory who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Center for Genetic Testing at Saint Francis. I understand that I am responsible for any co-pay or deductible amounts if the Center for Genetic Testing at Saint Francis is a participant in my health plan. I understand I am fully responsible for payment of my account if the Center for Genetic Testing at Saint Francis is not a participant with my health plan, and my health plan does not reimburse (or only partially reimburses) my medical services due to lack of authorization or medical necessity. **The information permitted for release may include records which indicate the presence of a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS), and/or mental health information.**

PATIENT / GUARANTOR - SIGNATURE _____ DATE _____

REFERRING FACILITY

FACILITY NAME	PHONE NUMBER	FAX NUMBER
BILLING ADDRESS	APPROVAL NUMBER - IF APPLICABLE	

OSDH

AUTHORIZATION NUMBER _____