

MOLECULAR (DNA) TEST REQUISITION
Center for Human Genetics, Inc.
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FOR CHG LAB USE ONLY:
Date received: _____
Pedigree #: _____
Family name: _____
Sample type: _____
Lab #: _____

Patient Name: _____
Last First MI
Hospital/Patient ID#: _____
Address: _____
City State Zip Code

Male **Female** **Unknown**
Date of Birth: ____ / ____ / ____
MM DD YYYY
Partner/Parent of: _____
Phone: (____) _____

Referring Provider: **NPI:**(10 digits required) _____
Name: _____
Address: _____
City State Zip Code
Phone: (____) _____ Fax: (____) _____
Genetic Counselor: _____

Referring Laboratory: (if different)
Name: _____
Address: _____
City State Zip Code
Phone: (____) _____ Fax: (____) _____

***** Billing information and copy of insurance card MUST accompany sample and requisition form. *****

Billing Information: (Select one) **Lab/Hospital/Institution** **Insurance (see below)** **Patient**

I authorize any holder of medical information about me to release to any insurance carrier any information needed for this claim. I permit a copy of this authorization to be used in place of the original and request that the payment of medical insurance be paid to CHG, Inc. I also understand that I will be held responsible for any portion of the claim that the insurance company does not pay.

Signed _____ Date _____
SIGNATURE REQUIRED

Insurance: (Please select)
 BLUE CROSS **HMO**
State: _____ Name of HMO: _____

Lab/Hospital/Institution Invoice:
Name _____
Address _____
City State Zip Code
Phone: (____) _____ Fax: (____) _____

Prefix # / Certificate # / Suffix # / Policy # / Group #: _____

COMMERCIAL INSURANCE
Name of insurance: _____

Subscriber's Date of Birth: ____ / ____ / ____
MM DD YYYY

MEDICAID #: (Please circle state: MA, NH, NJ, NY, PA) _____
Subscriber's Name: _____
Last First

Primary Care Physician Contact Information:
Name: _____
Phone: (____) _____

Relation to patient: _____
Insurance Company Contact Information:
Address: _____
City State Zip Code
Phone: (____) _____

MEDICARE #: (Signed waiver required. See below.) _____

Date of Birth: ____ / ____ / ____
MM DD YYYY
Medicare Provider #: 228243

Medicare Waiver
Beneficiary Name: _____
Beneficiary ID#: _____

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare payment standards, Medicare will deny payment for that service. The Center for Human Genetics believes that Medicare is likely to deny payment for molecular DNA testing.

Beneficiary Agreement: I have been notified by the Center for Human Genetics that, in my case, Medicare is likely to deny payment for the services identified below, for the reason stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Beneficiary Signature: _____ Date: _____

**MOLECULAR (DNA) TEST REQUISITION
CLINICAL INFORMATION:**

FOR CHG LAB USE ONLY:

Pedigree #: _____ Lab #: _____

Patient Name: _____ **Date of Birth:** ____/____/____

Last First MI MM DD YYYY

Ethnicity: Ashkenazi Jewish French Canadian Caucasian African American Asian Hispanic
 Sephardic Jewish Armenian Turkish Mediterranean Arabic Other: _____

Purpose of Study:

- Diagnosis
- Carrier Screen
- Prenatal Diagnosis
- Predictive/Presymptomatic**
- No family history (Call before sending samples)
- Family history*
- Ultrasound abnormality*
- Family history*

*Please include additional information: _____

Pregnancy information (if applicable): Gestational age _____ By LMP _____ By ultrasound _____
 Date Date Date

Name and relationship of family members previously tested at CHG: _____

Name of mutation to be tested (if known in family): _____

*****SPECIMEN REQUIREMENTS FOR ALL TESTS LISTED BELOW: 7-10 cc BLOOD IN EDTA OR ACD ANTICOAGULANT*****

**DNA TEST(S) REQUESTED:
(analysis = sequencing and MLPA available)**

Date Sample Collected: _____

- AML mutation panel
 - FLT3* common mutations
 - NPM1* exon 12 sequencing
- Angelman syndrome
 - Methylation studies
 - UBE3A* sequencing
- Ashkenazi Jewish panel
 - Bloom syndrome
 - Canavan disease
 - Cystic fibrosis
 - Factor XI deficiency
 - Familial Dysautonomia
 - Fanconi anemia Group C
 - Glycogen storage disease Type 1A
 - Gaucher disease
 - MSUD Type 1B
 - Mucopolidiosis type IV
 - Niemann-Pick disease Type A
 - Tay Sachs disease
- Ataxia panel
 - Spinocerebellar ataxia (circle tests)
Type 10, 12, 17
 - DRPLA
- Autism (with macrocephaly) (*PTEN* analysis)
- Banking
 - DNA
 - Lymphoblast
- BCR/ABL
- BRCA1/2 (Ashkenazi Jewish mutations only)**
- Cardiofaciocutaneous syndrome comprehensive panel
 - BRAF* sequencing only
 - MAP2K1* sequencing only
 - MAP2K2* sequencing only
 - KRAS* sequencing only
- Charcot-Marie-Tooth disease (Type 1B) (*CMT1B* sequencing)
- CHARGE syndrome (*CHD7* analysis)
- Colon Cancer
 - Familial Adenomatous Polyposis (*APC* analysis)
 - HNPCC (*MLH1*, *MSH2*, & *MSH6* analyses)
 - MYH* Associated Polyposis (*MUTYH* analysis)
- Congenital bilateral absence of vas deferens (CBAVD)
- Congenital Contractural Arachnodactyly (*FBN2* sequencing)
- Connexin 30 deletion (non-syndromic deafness)
- Costello syndrome comprehensive panel
 - HRAS* sequencing only
 - KRAS* sequencing only
 - BRAF* sequencing only
- Cystic fibrosis
 - 40 mutations
 - 100 mutations
 - CFTR* analysis
- Ehlers-Danlos syndrome Type IV (*COL3A1* analysis)
- Factor V Leiden
- Familial Aortic Aneurysm (*MYH11* sequencing)
- Familial Mediterranean Fever
 - Common mutations only
 - MEFV* sequencing
- Fragile X syndrome
- Hemochromatosis
- Huntington disease**
- JAK2 (V617F mutation [reflex to exon 12 sequencing])
- Kennedy disease (SBMA)
- LEOPARD syndrome comprehensive panel
 - PTPN11* sequencing only
 - RAF1* sequencing only
- Loews-Dietz syndrome
 - TGFBR1* analysis
 - TGFBR2* analysis
- Melanoma (*CDKN2A* analysis)
- Marfan syndrome (*FBN1* analysis)
- Maternal cell contamination studies
- MCAD
- MTHFR
- Mitochondrial diseases panel
 - All 37 gene sequencing
 - MELAS
 - CPEO/KSS
 - MERRF
 - LHON
 - NARP
 - Leigh syndrome
- Neurofibromatosis
 - NF1* analysis
 - NF2* analysis
- Noonan syndrome comprehensive panel
 - PTPN11* sequencing only
 - SOS1* sequencing only
 - KRAS* sequencing only
 - RAF1* sequencing only
- Paraganglioma (*SDHD* sequencing)
- Paternity testing (Call before sending samples)
- Pendred syndrome
- Phenylketonuria (*PAH* analysis)
- Prader-Willi syndrome
- Prothrombin (G20210A)
- PTEN* Hamartoma Tumor syndromes
(*PTEN* analysis and promoter sequencing)
 - Cowden syndrome
 - Bannayan-Riley-Ruvalcaba syndrome
 - Proteus syndrome
- Sickle cell anemia
- Smith-Lemli-Opitz syndrome (*DHCR7* sequencing)
- SNP microarray
- Sotos syndrome (*NSD1* analysis)
- Stickler syndrome Type 1 (*COL2A1* analysis)
- Tay-Sachs disease
- Thrombophilia panel
(Includes Factor V Leiden, Prothrombin, and MTHFR)
- Tuberous Sclerosis (*TSC1* analysis)
- UPD: chromosome _____
(Call before sending samples)
- Von-Hippel-Lindau disease (*VHL* analysis)
- Waardenburg syndrome
 - Types 1 and 3: *PAX3* analysis
 - Type 2: *MITF* analysis, *SOX10* analysis
 - Type 4: *SOX10* analysis
- Wilson disease (*ATP7B* analysis)
- X-inactivation studies
- X-linked lymphoproliferative disease (*SH2D1A* analysis)

- X-linked Mental Retardation
(Order XLMR panel, individual tiers, or single gene)
- Tier A
 - NLGN3* sequencing (Autism)
 - NLGN4* sequencing (Autism)
 - Rett syndrome (*MECP2* analysis)
 - Rett syndrome - atypical (*STK9/CDKL5* analysis)
- Tier 1
 - DLG3* sequencing
 - FTSJ1* sequencing
 - JARID1C* sequencing
 - Borjesen-Forsman-Lehmann syndrome: *PHF6* sequencing
 - ZNF41* sequencing
- Tier 2
 - Asperger syndrome: *GDI1* analysis
 - FACL4* analysis
 - OPHN1* analysis
 - Renpenning syndrome: *PQBP1* analysis
 - TM4SF2* analysis
- Tier 3
 - Alpha-thalassemia/mental retardation syndrome: *ATRX* sequencing
 - Aarskog Scott syndrome: *FGD1* analysis
 - OpitzG/BBB syndrome: *MID1* analysis
 - Pelizaeus-Merzbacher disease: *PLP1* analysis
 - Coffin-Lowry syndrome: *RSK2* analysis
 - Creatine (transporter) deficiency: *SLC6A8* analysis
- Other X-linked mental retardation genes
 - AGTR2* analysis
 - ARHGFE6* analysis
 - ATP6AP2* sequencing (with epilepsy)
 - PAK3* analysis
 - SYN1* sequencing (with epilepsy)
- Y-chromosome detection (SRY)
- Y-microdeletion studies
- Zygosity testing

Linkage Analysis
(Call before sending samples)
 Familial Adenomatous Polyposis (*APC*)
 Hemophilia A (*F8*)
 Phenylketonuria (*PAH*)

Other: _____

Patient Name: _____
Last First MI

Date of Birth: ____/____/____
MM DD YYYY

INFORMED CONSENT FOR DNA TESTING

I/We request and authorize the DNA Diagnostic Laboratory at the Center for Human Genetics to analyze a sample of DNA isolated from _____ (sample type) obtained on _____ (date) to assess the probability that I (my/our fetus/child) am (is) affected with or carry the gene for the genetic disease _____ which is _____.

The test procedure has been explained to me/us and I/we understand that:

I. There are several possible outcomes of this test:

1. The test results may indicate that it is likely or unlikely that I (my/our fetus/child) am (is) affected with, or a carrier for, the above disease.
2. The test results may be indeterminate because of my (my/our fetus'/child's) genetic patterns or the genetic patterns of my family members (if also tested), and/or the limitations of the current technology.

II. DNA tests are performed with precision and results reflect great accuracy and specific degrees of quoted accuracy (when applicable). Turn-around time is estimated and cannot be guaranteed.

III. One possible result of DNA testing is that the laboratory could discover evidence of previously undisclosed non-paternity when comparing my (my/our fetus'/child's) sample with samples from other family members.

IV. Genetic counseling, further testing, or additional physician consults may be warranted after testing in order to complete the testing process.

V. After the DNA testing of my (my/our fetus'/child's) sample is complete, DNA will be stored at the Center for Human Genetics for a minimum of three months. After that time, any remaining material will be disposed of at the discretion of the Laboratory Director, and may be used for medical research or education so long as our privacy is maintained.

VI. The results of this test are to be released only to the ordering physician and referral laboratory (if applicable) per HIPAA regulations.

My/our signature(s) below constitute(s) my/our acknowledgement (1) that the proposed DNA test(s) and its/their limitations for my/our specific situation have been satisfactorily explained to me/us by my/our physician or genetic counselor; and (2) I/we hereby give my/our authorization and consent for this testing.

Patient/Guardian Signature

Witness Signature

Date