



DNA DIAGNOSTIC LABORATORY REQUISITION FORM

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DATE SAMPLE DRAWN: ____/____/____

1/2002

COMPLETE A FORM FOR EACH SAMPLE SUBMITTED

PATIENT NAME: _____

DOB: ____/____/____ SEX: M / F / Unknown _____

ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE NO.:
HOME (____) _____ WORK (____) _____

PLEASE CHECK BOX(ES) BELOW TO INDICATE WHO SHOULD RECEIVE REPORT

REFERRING MD: _____

UPIN#: _____

HOSPITAL/INSTITUTION: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

TEL. NO.: (____) _____ FAX (____) _____

REFERRING GENETIC COUNSELOR / LABORATORY:

ADDRESS: _____

CITY, STATE, ZIP: _____

TEL. NO.: (____) _____ FAX (____) _____

Additional reports to: _____

BILLING INFORMATION

If this section is incomplete, the referring physician or hospital/laboratory will automatically be billed.

PAYMENT METHOD:

1. Self-Pay (Discounted fees for full payment with sample)
 Check or Money Order
 CC (AMX/MC/VISA) Account #: _____ Exp date: _____
Cardholder name: _____
Cardholder signature: _____

2. Referring Institution or MD
Provide previously assigned code, or complete information below:
Institution Code (as previously assigned): _____
(or) Institution Name: _____
Financial Contact: _____
Billing Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

3. Insurance (Insurance cannot be filed without the HMO authorization and ICD-9 code)
HMO, PPO, Commercial Ins - provide front/back copy of insurance card.
Texas Medicaid - provide current Texas Medicaid form 3087.
Texas Medicaid Managed Care - Authorization / current Texas Medicaid form 3087.
ICD-9 CODE: _____ Patient's diagnosis code must be provided.
Insured's Name: _____
Insured's SS #: _____ Authorization #: _____
Group: _____
Insurance Name: _____
Employer: _____
Insurance Address: _____
Insurance City, State, Zip: _____
Insurance Phone #: _____

Authorization to release information, assign benefits, and accept financial responsibility for my account.

I authorize any physician or lab 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 Baylor College of Medicine's, Dept. of Molecular & Human Genetics. I understand I am responsible for any co-pay or deductible amounts if the Dept of Molecular & Human Genetics is a participant with my health plan. I understand I am fully responsible for payment of my account balance if the Dept. of Molecular & Human Genetics 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.

Signature _____ Date _____

SPECIMEN TYPE: Blood Other (Specify): _____

IMPORTANT: Check The Test(s) requested

All tests are subject to change

- | | |
|--|---|
| <input type="checkbox"/> Achondroplasia (ACH) | <input type="checkbox"/> Lowe Syndrome (LOWE) |
| <input type="checkbox"/> Alpha-1-Antitrypsin Deficiency (ALPHA 1) | <input type="checkbox"/> Machado-Joseph Disease (SCA3) |
| <input type="checkbox"/> Angelman Syndrome Methylation (AS) | <input type="checkbox"/> Maternal Cell Contamination** (MCC) |
| <input type="checkbox"/> Angelman Syndrome Sequencing (UBE3A) | <input type="checkbox"/> MTHFR Variant Analysis (MTHFR) |
| <input type="checkbox"/> APC Ashkenazic Mutation I1307K* (APC) | <input type="checkbox"/> Myotonic Dystrophy (MDY) |
| <input type="checkbox"/> Ashkenazic Disease Screen (ADS)
<i>Canavan, CF, & Tay-Sachs DNA analysis</i> | <input type="checkbox"/> Niemann-Pick Disease Type A (NPD) |
| <input type="checkbox"/> Ashkenazic Disease Screen Plus (ADS+)
<i>Canavan, CF, & Tay-Sachs DNA + enzyme</i> | <input type="checkbox"/> Prader-Willi Syndrome Methylation (PWS) |
| <input type="checkbox"/> Bloom Syndrome/Ashkenazic (BLOOM) | <input type="checkbox"/> Prothrombin (PRO) |
| <input type="checkbox"/> Citrullinemia (CIT) | <input type="checkbox"/> Rett Syndrome Sequencing (RETT) |
| <input type="checkbox"/> Connexin 26/GJB2 (CX) | <input type="checkbox"/> RhD Genotyping (RHD) |
| <input type="checkbox"/> Cystic Fibrosis - 37 Mutations (CF-M) | <input type="checkbox"/> Sickle Cell Disease (SCD) |
| <input type="checkbox"/> Cystic Fibrosis - Linkage (CF-L) | <input type="checkbox"/> Spinal Muscular Atrophy (SMA) |
| <input type="checkbox"/> Cystic Fibrosis - 5T Variant Analysis for CBAVD (CF5T) | <input type="checkbox"/> Spinocerebellar Ataxia Panel (ATAXIA)
<i>(includes SCA1, SCA2, SCA3, SCA6 and SCA7)</i> |
| <input type="checkbox"/> DNA Banking (BANK) | <input type="checkbox"/> Spinocerebellar Ataxia Panel + SCA10 (ATAXIA II) |
| <input type="checkbox"/> DNA Preparation only | <input type="checkbox"/> Spinocerebellar Ataxia Panel + SCA10 + Friedreich Ataxia (ATAXIA III) |
| <input type="checkbox"/> Dentatorubral Pallidoluysian Atrophy (DRPLA) | <input type="checkbox"/> Spinocerebellar Ataxia 1 (SCA1) |
| <input type="checkbox"/> Duchenne/Becker Muscular Dystrophy (DMD) | <input type="checkbox"/> Spinocerebellar Ataxia 2 (SCA2) |
| <input type="checkbox"/> Factor V Leiden (F5) | <input type="checkbox"/> Spinocerebellar Ataxia 3 (SCA3) |
| <input type="checkbox"/> Factor VIII Deficiency/Hemophilia A (F8) | <input type="checkbox"/> Spinocerebellar Ataxia 6 (SCA6) |
| <input type="checkbox"/> Familial Dysautonomia (FD) | <input type="checkbox"/> Spinocerebellar Ataxia 7 (SCA7) |
| <input type="checkbox"/> Fragile X Syndrome (FX) | <input type="checkbox"/> Spinocerebellar Ataxia 10 (SCA10) |
| <input type="checkbox"/> Friedreich Ataxia (FRDA) | <input type="checkbox"/> SRY Analysis (SRY) |
| <input type="checkbox"/> Gaucher Disease Ashkenazic Mutations (GD) | <input type="checkbox"/> Thrombophilia Panel (THROM)
<i>(includes Factor V and Prothrombin)</i> |
| <input type="checkbox"/> Hemochromatosis (HH) | <input type="checkbox"/> Thrombophilia + MTHFR (THROM+) |
| <input type="checkbox"/> Huntington's Disease (HD) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Incontinentia Pigmenti (IP) | |
| <input type="checkbox"/> Kennedy Disease (KD) | |

*Requires research protocol **Required for all prenatal testing

Upon completion of testing, patient DNA sample may be used for anonymized research studies. YES NO

INDICATION FOR TESTING

1. If this patient is a symptomatic individual, please check the appropriate box:
 POSSIBLE DIAGNOSIS DEFINITE DIAGNOSIS

2. If this patient is an asymptomatic individual OR if this is a fetal sample, please check the appropriate box:

- | | |
|---|--|
| <input type="checkbox"/> PREVIOUS CHILD | <input type="checkbox"/> CARRIER SCREEN (General Population) |
| <input type="checkbox"/> FAMILY HISTORY | <input type="checkbox"/> PREGNANCY AT RISK |

IMPORTANT: ETHNIC BACKGROUND IS IMPORTANT FOR ACCURATE TEST INTERPRETATION

- | | |
|---|---|
| <input type="checkbox"/> NW EUROPEAN CAUCASIAN | <input type="checkbox"/> HISPANIC |
| <input type="checkbox"/> S EUROPEAN CAUCASIAN | <input type="checkbox"/> AFRICAN AMERICAN |
| <input type="checkbox"/> MIXED EUROPEAN CAUCASIAN | <input type="checkbox"/> NATIVE AMERICAN INDIAN |
| <input type="checkbox"/> ASHKENAZIC JEWISH | <input type="checkbox"/> ASIAN |
| <input type="checkbox"/> OTHER JEWISH | <input type="checkbox"/> OTHER _____ |

FAMILY HISTORY/CLINICAL SYMPTOMS: Please Complete

Indicate individuals to be studied with an asterisk (*) Provide full names and dates of birth If indicating pregnancy, PLEASE include LMP DATE

PLEASE SIGN CONSENT FORM ON NEXT PAGE



BAYLOR DNA DIAGNOSTIC LABORATORY

Informed Consent for DNA Testing

I, _____, hereby agree to participate in testing for (name of disease) _____, using a DNA-based test. I understand that samples of blood will be drawn from me and/or members of my family by removing blood from a vein, a procedure which carries very little risk. In addition, if prenatal diagnosis is involved, fetal cells obtained by amniocentesis or chorion villus sampling will be used. I understand that the blood and fetal samples will be used for the purpose of attempting to determine if I and members of my family are carriers of the disease gene, or are affected with, or at increased risk to someday be affected with this genetic disease.. In addition, I hereby give permission to collect blood samples from my minor children, named below, to be used for DNA testing for the disease listed above.

Child's Name

Date of Birth

Sex

I understand that:

1 In some cases the DNA test directly detects an abnormality, called a mutation, in the gene, and the test is >99% accurate. In other cases, an indirect method called linkage analysis is used. If linkage analysis is being used, naturally occurring rearrangements in the DNA (recombination) may produce an uncertainty in predicting carrier status of diagnosis. Rare variations in the DNA of individuals can also cause uncertainty in predicting carrier status of diagnosis. Thus, the test is not 100% accurate, and the results will be reported as a probability.

2 In some families, the markers may not be informative. If this is the case, this DNA test can not provide results for that family, or for some members of that family.

3 An error in the diagnosis may occur if the true biological relationships of the family members involved in this study are not as I have stated. For example, non-paternity means that the father of an individual is not the person stated to be the father. This test may detect non-paternity, and it may be necessary to report this finding to the individual who requested testing.

4 Any erroneous diagnosis in a family member can lead to an incorrect diagnosis for other related individuals in question. I understand that the DNA analysis performed at Baylor College of Medicine for this disease is specific only with respect to it and in no way guarantees my health or the health of my unborn child. The accuracy of DNA analysis is entirely dependent on the clinical diagnosis made elsewhere, and Baylor College of Medicine cannot be responsible for erroneous clinical diagnosis made at other centers.

5 In order to perform accurate prenatal diagnosis, blood samples are required from the affected individual in the family, both parents of the fetus and possibly from other members. We request the submission of both a direct and a cultured fetal specimen (amniotic fluid or CVS) or two sets of primary cultures for each prenatal study. All fetal studies will be performed twice, ideally on direct first and then on culture to confirm. The final report for a fetal analysis will be sent only after the confirmation study is complete.

6 Generally, these tests are relatively new and are being improved and expanded continuously. The tests are not considered research, but are considered to be the best and newest laboratory service which can be offered. This testing is often complex and utilizes specialized materials so that there is always some small possibility that the test will not work properly or that an error will occur. There is a low error rate (perhaps 1 in 1000 samples) even in the laboratories. My signature below acknowledges my voluntary participation in this test, but in no way releases the laboratory and staff from their professional and ethical responsibility to me.

7 I understand that my sample is not being banked. The laboratory does not return DNA samples to individuals or physicians. However, in some cases it may be possible for the laboratory to reanalyze my remaining DNA upon request. The request for additional studies must be ordered by my referring physician/counselor and there will be an additional fee.

8a Once my test result is completed, an aliquot of my DNA may be made anonymous (name and all other identifiers removed) and used for research purposes. Any results obtained could not be related to the original source, so no results would be reported.

8b I indicate my desire to opt out of participation in anonymized research studies using my DNA sample by checking this box.

9 Because of the complexity of DNA based testing and the important implications of the test results, results will be reported to me only through a physician or genetic counselor whom I designate. The result reports are confidential; they will only be released to other medical professionals or other parties with my written consent. All laboratory data is confidential and will not be released within legal limit. Participation in DNA testing is completely voluntary.

10 I will receive a copy of this consent form.

Signature: _____

Witnessed by: _____

Date: _____

Physician s/Counselor s Statement: I have explained DNA testing to this individual. I have addressed the limitations outlined above, and I have answered this person s questions.

Signature _____ Date _____