BAYLOR MIRACA GENETICS LABORATORIES

PHONE: 800-411-GENE | FAX: 713-798-2787 | www.bmgl.com

SHIP TO: Baylor Miraca Genetics Laboratories
2450 Holcombe, Grand Blvd. -Receiving Dock
Houston, TX 77021-2024
Phone: 713-798-6555

CUSTOM PROBAND SEQUENCING REQUISITION

PATIENT INFORMATION

NAME: _____ (LAST NAME) _____ (FIRST NAME) ___ (MI)

DATE OF BIRTH: ___ / ___ / ___ (MM DD YY)

GENDER (Please select one):
- ☐ FEMALE
- ☐ MALE
- ☐ UNKNOWN

-OR-
PLACE PATIENT STICKER HERE

SAMPLE INFORMATION

DATE OF COLLECTION: ___ / ___ / ___ (MM DD YY)

HOSPITAL#: _____ ACCESSION#: _____

SAMPLE TYPE (Please select one):
- ☐ BLOOD
- ☐ SALIVA
- ☐ DNA (Specify source): _____
- ☐ OTHER (Specify): _____

ETHNIC BACKGROUND (Select all that apply):
- ☐ AFRICAN AMERICAN
- ☐ ASIAN
- ☐ ASHKENAZIC JEWISH
- ☐ EUROPEAN CAUCASIAN
- ☐ HISPANIC
- ☐ NATIVE AMERICAN INDIAN
- ☐ OTHER JEWISH
- ☐ OTHER (Please specify): _____

REPORTING INFORMATION

PHYSICIAN: _____

INSTITUTION: _____

PHONE: _____ FAX: _____

EMAIL (INTERNATIONAL CLIENT REQUIREMENT): _____

ADDITIONAL PROFESSIONAL REPORT RECIPIENTS

NAME: _____

PHONE: _____ FAX: _____

NAME: _____

PHONE: _____ FAX: _____

This requisition is for request of confirmation of TARGETED mutation(s) and/or Variants of Unclear Clinical Significance (VUS) testing:

- Confirmation of test results that has not previously been completed in a CLIA/CAP lab (such as research lab results)
- Confirmation of proband's Whole Exome Sequencing (WES) results.

This requisition should only be used for confirmation of genes which the BMGL does not provide a separate specific test code. For confirmation of proband's Whole Exome Sequencing (WES) completed at BMGL, please provide the following and complete page 2:

BMGL LAB #: _____ BMGL FAMILY #: _____

☐ COPY OF ORIGINAL RESULTS ATTACHED (REQUIRED)

Records from the lab that identified the sequence change that is being requested MUST accompany this form. We will not be able to proceed with testing without documentation from the laboratory that identified the change. The lab report should include the mutation names at nucleotide level and if applicable, amino acid level and/or reference sequence number including version number (Ex: NM_000314.4). **NOTE: We are unable to accept samples from a research facility.**

If TARGETED testing on FAMILY member of the proband is desired either after or in conjunction with the Proband's testing please complete the "Family Member Custom Sequencing Requisition" for each family member available on our website (see test code 1580).

REQUIRED: NEW YORK STATE PHYSICIAN SIGNATURE OF CONSENT

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing.

Physician's Printed Name: _____ Signature: _____ Date (MM/DD/YY): _____

SEE PAGE 2 FOR TESTING OPTIONS

LAST UPDATED: 2/2015

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FOR AUTOSOMAL DOMINANT, HOMOZYGOUS, OR X-LINKED TARGETED GENE TESTING

Use the below test codes (1560-1569) for requests when confirmation of only ONE sequence change is being requested for that gene (i.e. autosomal dominant inheritance). Complete one test code request for EACH gene.

	TEST CODE	TEST NAME	GENE NAME (REQUIRED)	MUTATION/UNCLASSIFIED VARIANT (REQUIRED)
☐	1560	Custom Proband Sequence Analysis - Gene 1		
☐	1561	Custom Proband Sequence Analysis - Gene 2		
☐	1562	Custom Proband Sequence Analysis - Gene 3		
☐	1563	Custom Proband Sequence Analysis - Gene 4		
☐	1564	Custom Proband Sequence Analysis - Gene 5		
☐	1565	Custom Proband Sequence Analysis - Gene 6		
☐	1566	Custom Proband Sequence Analysis - Gene 7		
☐	1567	Custom Proband Sequence Analysis - Gene 8		
☐	1568	Custom Proband Sequence Analysis - Gene 9		
☐	1569	Custom Proband Sequence Analysis - Gene 10		

FOR AUTOSOMAL RECESSIVE TARGETED GENE TESTING

Use the below test codes (1570-1579) for requests when confirmation of TWO sequence changes are being requested for that gene (i.e. autosomal recessive inheritance). Complete one test code for EACH gene that TWO sequence changes are being confirmed.

	TEST CODE	TEST NAME	GENE NAME (REQUIRED)	FIRST: MUTATION/UNCLASSIFIED VARIANT (REQUIRED)	SECOND: MUTATION/UNCLASSIFIED VARIANT (REQUIRED)
☐	1570	Custom Proband Sequence Analysis - Gene 1			
☐	1571	Custom Proband Sequence Analysis - Gene 2			
☐	1572	Custom Proband Sequence Analysis - Gene 3			
☐	1573	Custom Proband Sequence Analysis - Gene 4			
☐	1574	Custom Proband Sequence Analysis - Gene 5			
☐	1575	Custom Proband Sequence Analysis - Gene 6			
☐	1576	Custom Proband Sequence Analysis - Gene 7			
☐	1577	Custom Proband Sequence Analysis - Gene 8			
☐	1578	Custom Proband Sequence Analysis - Gene 9			
☐	1579	Custom Proband Sequence Analysis - Gene 10			

LAST UPDATED: 2/2015

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CUSTOM PROBAND SEQUENCING REQUISITION

BILLING INFORMATION

IMPORTANT NOTICE: ONE OF THE THREE FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.
PLEASE FORWARD ALL BILLING QUESTIONS TO: MEDGENBILLING@BCM.EDU

PATIENT INFORMATION

PATIENT NAME (LAST,FIRST, MI): _____ PATIENT DATE OF BIRTH (MM/DD/YY): _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ EMAIL: _____

☐ PAYMENT OPTION 1 - INSTITUTION

BAYLOR MIRACA GENETICS LABORATORIES CAN ONLY RUN THIS TEST IF THE INSTITUTION ACCEPTS FINANCIAL RESPONSIBILITY FOR THE FULL PRICE OF THE TEST. PLEASE SIGN AND DATE BELOW THAT YOU ARE AN AGENT OF THE ORDERING INSTITUTION AND CAN ORDER GENETIC TESTING ON ITS BEHALF. TESTING WILL NOT BEGIN WITHOUT THIS SIGNATURE.

PRINTED NAME: _____ SIGNATURE: _____ DATE (MM/YY): _____

INSTITUTION NAME: _____ INSTITUTION CODE: _____

CONTACT NAME: _____ EMAIL (REQUIRED): _____

BILLING ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

☐ PAYMENT OPTION 2 - SELF-PAY (PAYMENT MUST ACCOMPANY SAMPLE)

☐ CREDIT CARD (PLEASE SELECT ONE): ◯ AMEX ◯ DISCOVER ◯ MC ◯ VISA

VALID CARD #: _____ EXPIRATION DATE (MM/YY): _____ CVC CODE: _____

CARDHOLDER PRINTED NAME: _____ CARDHOLDER SIGNATURE: _____

☐ CHECK/MONEY ORDER

☐ PAYMENT OPTION 3 - INSURANCE

PROVIDE A LEGIBLE PHOTOCOPY OF THE FRONT & BACK OF THE INSURANCE CARD OR HMO/MEDICAID HMO AUTHORIZATION/REFERRAL.

INSURED MEMBER'S INFORMATION

MEMBER NAME (Last, First, MI): _____ MEMBER DATE OF BIRTH (MM/DD/YY): _____ GENDER: ◯ FEMALE ◯ MALE

MEMBER POLICY #: _____ MEMBER SS #: _____ MEMBER GROUP #: _____

INSURANCE CO. NAME: _____ PHONE: _____

INSURANCE CO. ADDRESS: _____ CITY, STATE, ZIP: _____

ORDERING PROVIDER: _____

ICD9 Diagnosis Code(s) - must be provided or insurance cannot be filed: _____

INSURANCE FINANCIAL POLICY: I UNDERSTAND THAT INSURANCE IS FILED TO BAYLOR MIRACA GENETICS LABORATORIES' CONTRACTED CARRIERS AS A CLIENT SERVICE COURTESY. I AM AWARE THAT I AM RESPONSIBLE FOR NON-COVERED SERVICES, DEDUCTIBLES, CO-INSURANCE, CONTRACT EXCLUSIONS, NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I AUTHORIZE BAYLOR MIRACA GENETICS LABORATORIES TO FURNISH ANY MEDICAL INFORMATION REQUESTED ON MYSELF, OR MY COVERED DEPENDENTS. IN CONSIDERATION OF SERVICES RENDERED, I TRANSFER AND ASSIGN ANY BENEFITS OF INSURANCE TO BAYLOR MIRACA GENETICS LABORATORIES.

☐ I have read and agree to all sections of the insurance financial policy above - TESTING WILL NOT BEGIN WITHOUT THIS SIGNATURE

PRINTED NAME: _____ SIGNATURE: _____ DATE (MM/YY): _____

LAST UPDATED: 2/2015