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 FAMILY 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: _____

Test Codes 1580-1589 are to be used when requesting sequencing of a known familial mutation(s) and/or Variants of Unclear Clinical Significance (VUS) for which the BMGL does not provide a separate test code. These should only be used when the BMGL has already identified the sequence change in the proband/original patient using Sanger sequencing methodologies. If proband testing was performed at another lab, call to discuss prior to sending sample. A positive control may be required in some cases. If testing of proband is needed, see separate requisition "Proband Custom Sequencing Analysis" (see web site for test code 1560) .

THIS FAMILY MEMBER IS CURRENTLY: ☐ ASYMPTOMATIC ☐ SYMPTOMATIC*

*If symptomatic, please provide details (attach additional pages if needed):

NAME OF FIRST PATIENT STUDIED: _____

RELATIONSHIP TO PERSON ABOVE: _____

BMGL LAB # OF PERSON ABOVE: _____ BMGL FAMILY #: _____

☐ COPY OF ORIGINAL RESULTS ATTACHED (REQUIRED)

Include a pedigree showing familial relationships

Please select one test code per gene for which targeted sequencing is being ordered:

	TEST CODE	TEST NAME	GENE NAME (REQUIRED)	MUTATION/UNCLASSIFIED VARIANT (REQUIRED)
☐	1580	Custom Family Member Sequence Analysis - Gene 1		
☐	1581	Custom Family Member Sequence Analysis - Gene 2		
☐	1582	Custom Family Member Sequence Analysis - Gene 3		
☐	1583	Custom Family Member Sequence Analysis - Gene 4		
☐	1584	Custom Family Member Sequence Analysis - Gene 5		
☐	1585	Custom Family Member Sequence Analysis - Gene 6		
☐	1586	Custom Family Member Sequence Analysis - Gene 7		
☐	1587	Custom Family Member Sequence Analysis - Gene 8		
☐	1588	Custom Family Member Sequence Analysis - Gene 9		
☐	1589	Custom Family Member Sequence Analysis - Gene 10		

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): _____

LAST UPDATED: 2/2015

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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