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

BIOCHEMICAL TESTING REQUISITION FORM

PATIENT INFORMATION

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

ADDRESS: _____ PHONE #: _____

DATE OF BIRTH: ____ (MM) / ____ (DD) / ____ (YY) GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

HOSPITAL #: _____ ACCESSION #: _____

REPORTING INFORMATION

PHYSICIAN: _____

INSTITUTION: _____

PHONE: _____ FAX: _____

EMAIL (INTERNATIONAL CLIENT REQUIREMENT): _____

ADDITIONAL PROFESSIONAL REPORT RECIPIENTS

NAME: _____

PHONE: _____ FAX: _____

NAME: _____

PHONE: _____ FAX: _____

SAMPLE INFORMATION

CHECK ALL THAT APPLY

SAMPLE TYPE:	DATE OF COLLECTION (MM/DD/YY):
☐ PLASMA	____ / ____ / ____
☐ URINE	____ / ____ / ____
☐ CEREBRAL SPINAL FLUID	____ / ____ / ____
☐ SKIN FIBROBLAST CULTURE	____ / ____ / ____
☐ SERUM	____ / ____ / ____
☐ WHOLE BLOOD (SODIUM HEPARIN - GREEN TOP)	____ / ____ / ____
☐ WHOLE BLOOD (ACD - YELLOW TOP)	____ / ____ / ____
☐ LIVER	____ / ____ / ____
☐ OTHER (please specify): _____	____ / ____ / ____

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): _____

BILLING INFORMATION

Complete Billing Information is REQUIRED prior to sample processing and analysis

☐ **SELF PAY (PAYMENT MUST ACCOMPANY SAMPLE):**

☐ CHECK/MONEY ORDER AMOUNT: _____

☐ CREDIT CARD AMOUNT: _____

CARD #: _____

◯ AMEX ◯ DISCOVER ◯ MC ◯ VISA EXP. DATE: _____

CVC CODE: _____ ZIP CODE: _____

CARDHOLDER NAME: _____

CARDHOLDER SIGNATURE: _____

☐ **INSTITUTION:**

INSTITUTION CODE: _____

INSTITUTION NAME: _____

ADDRESS: _____

CONTACT NAME: _____

CONTACT PHONE: _____

☐ **INSURANCE (PROVIDE COPY OF FRONT/BACK OF INSURANCE CARD):**

PERFORM BENEFITS VERIFICATION PRIOR TO TESTING: ◯ YES ◯ NO ICD9 DIAGNOSIS CODE(S): _____

ORDERING PROVIDER: _____ PATIENT'S RELATIONSHIP TO INSURED: _____

INSURED MEMBER'S INFORMATION:

NAME (Last, First, MI): _____ GENDER: ☐ FEMALE ☐ MALE

D.O.B. (MM/DD/YY): _____ SSN #: _____

GROUP#: _____ POLICY #: _____

INSURANCE CO. NAME: _____ INSURANCE CO. PHONE: _____

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

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 understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for any payment of my account if Baylor Miraca Genetics Laboratories is not a participant with my health plan, and my health plan does not fully reimburse my medical services.

Print Name: _____

Signature: _____ Date: _____

Contact medgenbilling@bcm.edu with questions.

INDICATIONS ARE REQUIRED. PLEASE FILL OUT CHECKLIST ON PAGE 4

SEE PAGES 2 & 3 FOR TESTING OFFERED

LAST UPDATED: 5/2015

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SEVERE COMBINED IMMUNODEFICIENCY (SCID) NEWBORN SCREENING FOLLOW-UP PANEL

☐ 4001

This panel includes the following tests:
- Adenosine Deaminase Deficiency Enzyme (4509)
- Purine Nucleoside Phosphorylase Deficiency Enzyme (4592)
- Urine Purine Panel (4220)
- CMA-HR (180K High Resolution Copy Number ≥30Kb) (8655)

SPECIMEN REQUIREMENTS:
Sample types below must be shipped overnight:
BLOOD: All Blood samples must be shipped at ambient temperature.
- 2-3 cc in EDTA (purple-top) tube
- 1-2 cc in Sodium Heparin (green-top) tube
- 3-5 cc in ACD (yellow-top) tube

URINE: 2-4 cc. Do not add preservatives. Urine must be shipped frozen with dry ice.

NEONATAL AND INFANTILE METABOLIC SEIZURES PANEL

☐ 4400

This panel includes the following tests:
- PLASMA: Acylcarnitine Analysis (4300); Amino Acid Analysis (4100); Creatine/Guanidinoacetate Determination (4130); Pyridoxine-Dependent Seizures Panel (4811)
- CSF: Amino Acid Analysis (4160); Pyridoxine-Dependent Seizures Panel (4812)
- SERUM: Biotinidase Deficiency (4555)
- URINE: Organic Acid Screen (4200); Purine and Pyrimidine Panel (4010); Sulfocysteine Determination (4225)

SPECIMEN REQUIREMENTS:
All sample types below must be shipped frozen with dry ice and overnight:
PLASMA: 2-3cc
CSF: 0.5-1cc
SERUM: 1-2 cc
URINE: 2-4 cc. Do not add preservatives.

BIOCHEMISTRY MULTI-PLEX AUTISM PANEL

☐ 4000

This panel includes the following tests:
- PLASMA: Acylcarnitine Analysis (4300); Amino Acid Analysis (4100); Creatine/Guanidinoacetate Determination (4130)
- URINE: Carnitine Biosynthesis Panel (4135); Creatine/Guanidinoacetate Determination (4260); Organic Acid Screen (4200); Purine Panel (4220); Pyrimidine Panel (4215)

SPECIMEN REQUIREMENTS:
All sample types below must be shipped frozen with dry ice and overnight:
PLASMA: 2cc
URINE: 3-5cc

BIOCHEMISTRY 5-PLEX AUTISM PANEL (URINE ONLY)

☐ 4165

This panel includes the following tests:
- URINE: Carnitine Biosynthesis Panel (4135); Creatine/Guanidinoacetate Determination (4260); Organic Acid Screen (4200); Purine Panel (4220); Pyrimidine Panel (4215)

SPECIMEN REQUIREMENTS:
All sample types below must be shipped frozen with dry ice and overnight:
URINE: 3-5cc

BIOCHEMISTRY 3-PLEX AUTISM PANEL (PLASMA ONLY)

☐ 4175

This panel includes the following tests:
- PLASMA: Acylcarnitine Analysis (4300); Amino Acid Analysis (4100); Creatine/Guanidinoacetate Determination (4130)

SPECIMEN REQUIREMENTS:
All sample types below must be shipped frozen with dry ice and overnight:
PLASMA: 2cc

ANALYTE PANEL TESTS

Carnitine Biosynthesis Panel		
☐	4135	URINE
☐	4145	PLASMA
☐	4155	CSF
Creatine Deficiency Syndromes Panel		
☐	4015	PLASMA AND URINE

Polyols		
☐	4340	URINE
Purine Panel		
☐	4220	URINE
Purine and Pyrimidine Panel		
☐	4010	URINE

Pyridoxine-Dependent Seizures Panel		
☐	4811	PLASMA
☐	4812	CSF
Pyrimidine Panel		
☐	4215	URINE

INDICATIONS ARE REQUIRED. PLEASE FILL OUT CHECKLIST ON PAGE 4

SEE PAGE 3 FOR INDIVIDUAL ANALYTE AND ENZYME TESTS

LAST UPDATED: 5/2015

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INDIVIDUAL ANALYTE ANALYSIS

25-Hydroxyvitamin D2 and D3		
☐	4360	SERUM
Acylcarnitine Analysis		
☐	4300	PLASMA
Acylglycine Determination		
☐	4350	URINE
Amino Acid Analysis		
☐	4100	PLASMA
☐	4160	CSF
☐	4240	URINE
Blood spot Phe/Tyr		
☐	4120	Blood spot
Carnitine Determination		
☐	4310	PLASMA

Coenzyme Q10 Determination		
☐	4800	MUSCLE
Creatine/Guanidinoacetate Determination		
☐	4130	PLASMA
☐	4260	URINE
Cystine Determination		
☐	4627	WHITE BLOOD CELLS
Homocysteine Determination		
☐	4140	PLASMA
Methylmalonic Acid		
☐	4150	PLASMA
Organic Acid Screen		
☐	4200	URINE
Orotic/Orotidine Determination		
☐	4210	URINE

Phenylalanine Determination		
☐	4110	PLASMA
Phenylbutyrate Metabolite Analysis		
☐	4650	PLASMA
☐	4651	URINE
☐	4652	CSF
Sulfocysteine Determination		
☐	4225	URINE
Succinylacetone Determination		
☐	4250	URINE
Succinyladenosine		
☐	4180	CSF
Thymidine Determination		
☐	4330	PLASMA

INDIVIDUAL ENZYME ANALYSIS

Adenosine Deaminase Deficiency		
☐	4509	RED BLOOD CELLS*
☐	4510	SKIN FIBROBLAST CULTURE
☐	4511	WHITE BLOOD CELLS
Argininemia / Arginase Deficiency		
☐	4535	LIVER
☐	4536	RED BLOOD CELLS*
Argininosuccinic Aciduria / Argininosuccinate Lyase Deficiency		
☐	4523	LIVER
☐	4524	RED BLOOD CELLS*
☐	4525	SKIN FIBROBLAST CULTURE
Aspartylglucosaminuria / Aspartylglucosaminidase Deficiency		
☐	4514	SKIN FIBROBLAST CULTURE
Biotinidase Deficiency		
☐	4555	SERUM
Carbamoyl Phosphate Synthetase I Deficiency		
☐	4561	LIVER
Citrullinemia / Argininosuccinate Synthetase Deficiency		
☐	4544	LIVER
☐	4545	SKIN FIBROBLAST CULTURE*
Fabry Disease/Alpha-Galactosidase A		
☐	4516	SKIN FIBROBLAST CULTURE
☐	4517	WHITE BLOOD CELLS*

Gaucher Disease / Beta-Glucosidase		
☐	4553	SKIN FIBROBLAST CULTURE*
☐	4554	WHITE BLOOD CELLS
GM1 Gangliosidosis (Morquio B, MPS IVB) / Beta-Galactosidase		
☐	4548	SKIN FIBROBLAST CULTURE
☐	4549	WHITE BLOOD CELLS*
Krabbe Disease / Galactocerebrosidase		
☐	4565	SKIN FIBROBLAST CULTURE
☐	4566	WHITE BLOOD CELLS*
Lowe Syndrome / Phosphatidylinositol Bisphosphate Phosphatase		
☐	4585	SKIN FIBROBLAST CULTURE
Lesch-Nyhan Disease / Hypoxanthine-Guanine Phosphoribosyltransferase		
☐	4573	SKIN FIBROBLAST CULTURE
Metachromatic Leukodystrophy / Arylsulfatase A Deficiency		
☐	4537	SKIN FIBROBLAST CULTURE
☐	4538	WHITE BLOOD CELLS*
Mucolipidosis I (Sialidosis) / Sialidase		
☐	4603	SKIN FIBROBLAST CULTURE
Mucopolysaccharidosis Type I / Alpha-L-iduronidase		
☐	4575	SKIN FIBROBLAST CULTURE
☐	4576	WHITE BLOOD CELLS*

Niemann-Pick Disease Types A & B / Sphingomyelinase		
☐	4607	SKIN FIBROBLAST CULTURE
☐	4608	WHITE BLOOD CELLS*
Ornithine Transcarbamylase Deficiency		
☐	4582	LIVER
Purine Nucleoside Phosphorylase Deficiency		
☐	4592	RED BLOOD CELLS*
☐	4593	SKIN FIBROBLAST CULTURE
☐	4594	WHITE BLOOD CELLS
Tay-Sachs Disease & Sandhoff Disease / Hexosaminidase A and B		
☐	4569	SERUM
☐	4617	SERUM**
☐	4620	WHITE BLOOD CELLS**
Wolman Disease / Cholesteryl Ester Storage Disease / Acid Lipase Deficiency		
☐	4502	LIVER
☐	4503	SKIN FIBROBLAST CULTURE
☐	4504	WHITE BLOOD CELLS*
X-Linked Ichthyosis / Steroid Sulfatase		
☐	4614	SKIN FIBROBLAST CULTURE
☐	4615	WHITE BLOOD CELLS

*PREFERRED SAMPLE TYPE
**TAY-SACHS DISEASE CARRIER TESTING

INDICATIONS ARE REQUIRED. PLEASE FILL OUT CHECKLIST ON PAGE 4

LAST UPDATED: 5/2015

BAYLOR MIRACA GENETICS LABORATORIES

INDICATION CHECKLIST

PATIENT NAME: _____ _____ ____
LAST NAME FIRST NAME MI

☐ Clinical management of known diagnosis - Please specify: _____

☐ Diagnostic Testing - Please complete checklist below.

Please indicate whether each feature is PRESENT by checking the box beside the indication below

CENTRAL NERVOUS SYSTEM			
☐	101	dd	Developmental Delay/ID
☐	102	ht	Hypotonia
☐	103	au	Autistic Features
☐	104	enc	Dementia/Encephalopathy
☐	105	ha	Headaches/Migraines
☐	106	stk	Stroke, Ischemic Episodes
☐	107	atx	Ataxia
☐	108	sz	Intractable/Refractory/Myoclonus/ Myoclonic Seizures
☐	109	pi	Perinatal Insult
☐	110	ps	Pyramidal Signs
☐	111	hp	Hemiparesis
☐	112	spas	Spasticity
☐	113	dyst	Dystonia
☐	114	cho	Chorea
☐	115	sib	Self-Injury
☐	116	sd	Language Problems/Speech Delay
☐	117	fp	Feeding Problems
☐	118	es	Excessive Sleepiness/Sleep Disturbance
☐	119	let	Lethargy
☐	120	cm	Coma
NEUROMUSCULAR			
☐	201	pn	Peripheral Neuropathy
☐	202	exi	Exercise Intolerance
☐	203	pmw	Progressive Muscle Weakness
☐	204	smw	Static Muscle Weakness
☐	205	cr	Muscle Cramps after Exercise
☐	206	fat	Easy Fatigability
☐	207	dcmyo	Dilated Cardiomyopathy
☐	208	hcmyo	Hypertrophic Cardiomyopathy
☐	209	hb	Heart Block
☐	210	ar	Arrhythmia
☐	211	op	Ophthalmoparesis, CPEO
☐	212	emg	Abnormal EMG/NCV
☐	213	pto	Ptosis
☐	214	eh	Cardiomegaly/Enlarged heart
VISCERAL			
☐	301	gir	Gastrointestinal Reflux
☐	302	dge	Delayed Gastric Emptying
☐	303	pan	Pancreatitis
☐	304	dia	Diarrhea
☐	305	cst	Constipation
☐	306	cv	Cyclic Vomiting
☐	307	pob	Pseudoobstruction
☐	308	hpf	Hepatic Failure

VISCERAL (cont.)			
☐	309	eta	Elevated Transaminases
☐	310	rtd	Renal Tubular Disease
☐	311	ap	Apnea/Hypoventilation
☐	312	rsf	Respiratory Deficiency/Failure
☐	313	ren	Renal Dysfunction
☐	314	lc	Liver Carcinoma
☐	315	jau	Jaundice
☐	316	spm	Splenomegaly/Enlarged Spleen
☐	317	hpm	Hepatomegaly/Enlarged Liver
☐	318	hd	Hepatic Dysfunction
METABOLITES/METABOLIC			
☐	400	nbs	Abnormal Newborn Screen: _____
☐	401	kto	Ketosis
☐	402	dca	Dicarboxylic Aciduria
☐	403	la	Lactic Acidosis
☐	404	csfl	High CSF Lactate
☐	405	oa	Organic Aciduria: _____
☐	406	lpc	Low Plasma Carnitine
☐	407	cpk	CPK abnormalities
☐	408	pyr	Elevated Pyruvate
☐	409	ala	Elevated Alanine
☐	410	3mg	3-Methylglutaconic Aciduria
☐	411	acid	Acidosis
☐	412	NH3	Hyperammonemia
☐	413	hypo	Hypoglycemia
☐	414	hyper	Hyperglycemia
☐	415	uco	Unusual Color/Odor
SENSORY			
☐	501	rp	Retinitis Pigmentosa
☐	502	opa	Optic Atrophy
☐	503	cat	Cataract
☐	504	hl	Sensorineural Hearing Loss
☐	505	trv	Tortuous Retinal Vessels
☐	506	crs	Cherry Red Spot/Eye
☐	507	co	Corneal Opacity
☐	508	el	Ectopia Lentis
☐	509	pp	Photophobia
ENDOCRINE			
☐	601	db	Diabetes
☐	602	pd	Exocrine/Pancreatic Deficiency
☐	603	gf	Gonadal Failure
☐	604	hth	Hypothyroidism
☐	605	hpt	Hypoparathyroidism
☐	606	adr	Hypo/Hyper-adrenal Function
☐	607	ss	Short Stature

ENDOCRINE (cont.)			
☐	608	adc	Adrenal Calcification
☐	609	hf	Hydrops Fetalis
☐	610	pg	Pregnant
OTHER CLINICAL			
☐	701	ftt	Failure to Thrive
☐	702	mce	Microcephaly
☐	703	sids	SIDS/Unexplained Death
☐	704	ca	Congenital Anomalies
☐	705	dys	Dysmorphic Features
☐	706	id	Immunodeficiency
☐	707	ma	Macrocytic Anemia
☐	708	pcbm	Pancytopenia/Bone Marrow Failure
☐	709	np	Neutropenia
☐	710	mc	Macrocephaly
☐	711	cf	Course Features
☐	712	sa	Skeletal Anomalies
☐	713	art	Arthritis
HAIR/SKIN FINDINGS			
☐	714	rash	Rashes w/Hypopigmentation
☐	715	htii	Hypertrichosis
☐	716	alp	Alopecia
☐	717	ac	Acrocyanosis
☐	718	ak	Angiokeratoma
☐	719	ic	Ichthyosis
FAMILY HISTORY			
☐	001	mut	Mutation*
☐	002	mi	Evidence of Maternal Inheritance
ELECTROPHYSIOLOGY			
☐	801	baers	Abnormal BAERS
☐	802	vers	Abnormal VERS
☐	803	eeg	Abnormal EEG
IMAGING/OTHER STUDIES			
☐	804	bg	Increased Signal Basal Ganglia
☐	805	dmy	Delayed Myelination
☐	806	cea	Cerebellar Atrophy
☐	807	pstk	Posterior Stroke
☐	808	leuk	Leukodystrophy
☐	809	mrsl	MRS/Lactate Peak
☐	810	mri	Abnormal MRI
MUSCLE BIOPSY			
☐	901	his	Abnormal Histology
☐	902	em	Abnormal Ultrastructure (EM)
☐	903	enz	Abnormal Respiratory Enzymes
☐	904	prol	Large Mitochondria/Proliferation
☐	905	cox	COX Deficiency
☐	906	rrf	Ragged Red Fibers

* ATTACH DETAILS

If more detailed clinical information is required, please provide the name, e-mail address, and phone number of the contact person below.