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

OVERGROWTH PANEL

PATIENT INFORMATION

NAME: _____ _____ ___
LAST NAME FIRST NAME MI

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

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

MEDICAL RECORD #: _____

ACCESSION #: _____

HOSPITAL #: _____

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: _____

SAMPLE INFORMATION

1 AFFECTED TISSUE (Choose one of the following):

- ☐ 9720 - Fresh tissue
- ☐ 9720 - Cultured cells (two T25 flasks)

DATE OF COLLECTION: ____ / ____ / ____ ☐ TO BE SENT LATER

AND

UNAFFECTED TISSUE (Choose one of the following):

- ☐ 9141 - Fresh tissue
- ☐ 9141 - Cultured cells (two T25 flasks)
- ☐ 9141 - Whole blood (5 ml in EDTA purple-top tube)

DATE OF COLLECTION: ____ / ____ / ____ ☐ TO BE SENT LATER

IF POSSIBLE, PLEASE SEND BOTH AFFECTED AND UNAFFECTED TISSUES SIMULTANEOUSLY.
IF NOT, SEND A COPY OF THIS FORM WITH EACH TISSUE.

2 UNAFFECTED TISSUE ONLY (AFFECTED TISSUE IS UNAVAILABLE)
NOTE: It is preferred to receive both affected and unaffected tissues. Not testing an affected tissue may decrease likelihood of detecting a mutation.

- ☐ 9720 - Whole blood (5 ml in EDTA purple-top tube)

DATE OF COLLECTION: ____ / ____ / ____

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: ◯ AMEX ◯ DISCOVER ◯ MC ◯ VISA AMOUNT: _____

CARDHOLDER NAME: _____

CARDHOLDER SIGNATURE: _____

CARD #: _____

EXP. DATE: _____ CVC CODE: _____ ZIP CODE: _____

☐ **INSTITUTION -** PROVIDE INSTITUTION NAME: _____

ADDRESS: _____ INSTITUTION CODE: _____

CONTACT NAME: _____ CONTACT PHONE: _____

☐ **INSURANCE (Provide a copy of the FRONT/BACK of insurance card)**

PERFORM BENEFITS VERIFICATION PRIOR TO TESTING: ◯ YES ◯ NO

ORDERING PROVIDER: _____

INSURED MEMBER'S INFORMATION:

NAME (Last, First, MI): _____

GENDER: ☐ FEMALE ☐ MALE D.O.B. (MM/DD/YY): _____

GROUP#: _____ POLICY #: _____

INSURANCE CO. NAME: _____

INSURANCE CO. PHONE: _____

INSURANCE CO. ADDRESS: _____

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.

Printed Name: _____

Signature: _____

Date (MM/DD/YY): _____

Contact medgenbilling@bcm.edu with questions.