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

Global MAPS℠ - Small Molecule

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#: ______________

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: ______________

PANELS

TEST CODE	SAMPLE TYPE	SPECIMEN REQUIREMENTS
☐ 4900	Plasma	Draw blood in a EDTA (purple top) tube(s) and separate as soon as possible, freezing immediately. Send 1-2 cc of plasma. Store the specimen frozen at -20C. Specimen may be stored frozen for up to 7 days. Ship frozen on 3-5 lbs of dry ice in an insulated container by overnight courier.
☐ 4902	Cerebrospinal fluid	Send 1-2 cc of cerebrospinal fluid. Store the specimen frozen at -20 C. Specimen may be stored frozen for up to 7 days. Ship frozen on 3-5 lbs dry ice in an insulated container by overnight courier.

Reporting:
Turnaround time is 3 weeks after financial responsibility has been verified to receive the focused report. Once the focused report is received the expanded report can be ordered (no additional charge). A requisition for ordering the expanded report is available on our website. Please allow 2 weeks for the expanded report. For more details regarding the reporting system please visit our website or call.

PREVIOUS TESTING

☐ Metabolic Testing (ex: Newborn screening, amino acid analysis) - if checked please describe:

☐ Chromosomal Microarray Analysis (CMA) - if checked please describe:

☐ Genetic Analysis - if checked please describe:

REQUIRED - INDICATION FOR STUDY

Please provide the following clinical information regarding the patient to be tested. If answering "yes," please provide additional description as appropriate (e.g., percentiles for growth parameters, type of limb abnormality, etc.). Please also submit a clinic note and pedigree if available. This information is needed to facilitate interpretation of metabolic profiling results. If the laboratory requires additional information, please indicate the health care provider to be contacted:

HEALTHCARE PROVIDER NAME: ______________ PHONE/PAGER #: ______________

INDICATIONS CONTINUED ON PAGE 2

LAST UPDATED: 2/2015

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NAME: ______ (LAST NAME) ______ (FIRST NAME) ___ (MI) DATE OF BIRTH: ___ (MM) / ___ (DD) / ___ (YY) GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

REQUIRED - INDICATION FOR STUDY (cont.)

Patient should NOT be on TPN, special diet, dietary supplements, or drug therapies for most accurate results.

Please list all medications and or supplements the patient has been prescibed and is currently taking:

	YES (Provide Description)		NO	UNKNOWN
Prematurity	☐		☐	☐
Intrauterine growth restriction	☐		☐	☐
Delayed motor milestones	☐		☐	☐
Delayed speech	☐		☐	☐
Developmental regression	☐		☐	☐
Autism/Autistic spectrum	☐		☐	☐
Intellectual disability	☐		☐	☐
Hearing loss	☐		☐	☐
Hypotonia	☐		☐	☐
Hypertonia/Spasticity	☐		☐	☐
Seizure disorder	☐		☐	☐
Ataxia	☐		☐	☐
Abnormal movements	☐		☐	☐
Dysmorphic features	☐		☐	☐
Short stature	☐		☐	☐
Tall habitus	☐		☐	☐
Microcephaly	☐		☐	☐
Macrocephaly	☐		☐	☐
Hyperextensibility	☐		☐	☐
Joint contractures	☐		☐	☐
Obesity/Overgrowth	☐		☐	☐
Failure to thrive	☐		☐	☐
Leukodystrophy	☐		☐	☐
Structural brain abnormalities	☐		☐	☐
Eye problems	☐		☐	☐
Heart problems	☐		☐	☐
Kidney problems	☐		☐	☐
GI/Liver problems	☐		☐	☐
Skeletal abnormalities	☐		☐	☐

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NAME: ______________ LAST NAME ______________ FIRST NAME ___ MI DATE OF BIRTH: ____ MM / ____ DD / ____ YY GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

REQUIRED - INDICATION FOR STUDY (cont.)

	YES (Provide Description)		NO	UNKNOWN
Skin anomalies	☐		☐	☐
Genital anomalies	☐		☐	☐
Organomegaly	☐		☐	☐
Lethargy	☐		☐	☐
Unusual odor	☐		☐	☐
Vomiting	☐		☐	☐
Dietary Avoidances	☐		☐	☐
Family history of similar disorder	☐		☐	☐

CHECKLIST OF ITEMS TO INCLUDE

☐ PROBAND SAMPLE ☐ INDICATION FOR STUDY CHECK LIST ☐ PEDIGREE

☐ REQUISITION ☐ CLINICAL NOTE/SUMMARY

Additional Studies- RESEARCH

After your results are finalized and reported there may be research studies that you may be eligible for and may be of interest to you. Please read the following statements carefully and check the appropriate box. If the "YES"/contact option is chosen please complete the additional information requested. Please note that if neither box is checked the lab will default to the "NO"/ no contact option.

_____ Initial ☐ YES, Baylor Miraca Genetics Laboratories may share my contact information with researchers who have an Institutional Review Board (IRB) approved research study for which I may be eligible for participation. There is no obligation to participate if contacted. No information, other than the contact information below, will be provided to the researcher.

Authorization:

Signature: ______________________ Date: ______________

Printed Name: ______________________

Patient Name: ______________________ Relationship to Patient: ______________

Contact Information:

Phone #: ______________________ Alternative Phone #: ______________

Address: ______________________ ______________ City ______________ State ______________ Zip Code

E-mail: ______________________

Preferred method of contact: ☐ Email ☐ Mail ☐ Phone

_____ Initial ☐ NO, I DO NOT wish to be contacted regarding participation in research studies.

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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