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

TRIO WHOLE EXOME 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
☐ EXTRACTED DNA FROM: _____
☐ FIBROBLAST
☐ CORD BLOOD

NOTE: Blood should not be sent from patients who have had a bone marrow transplant or recent blood transfusion

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: _____

WHOLE EXOME TEST MENU (select only ONE test)

☐ 1600 Trio Whole Exome Sequencing
☐ 1532 Trio Whole Exome Sequencing PLUS comprehensive MtDNA analysis - Send 2 separate EDTA tubes of blood
☐ 1722 Critical Trio Whole Exome Sequencing
☐ 1533 Critical Trio Whole Exome Sequencing PLUS comprehensive MtDNA analysis - Send 2 separate EDTA tubes of blood

For All Trio WES Orders: Parental samples are REQUIRED. Testing cannot proceed unless both biological parental samples are received. If all three familial samples cannot be sent together the samples will be prepped and held until all necessary samples are received. Testing will be cancelled if all three samples do not arrive within 8 weeks after receipt of the 1st sample. Please consider Proband Whole Exome Sequencing (1500) if all three familial samples cannot be collected. Turnaround time is 10 weeks AFTER financial responsibility has been verified by the BMGL billing office.

For Critical Trio WES (1722, 1533): Please limit ordering this test to critically ill patients only. This is only available for institutional bill or self pay patients. Turnaround time is 3 weeks. Please see note above regarding necessity of sending biological parental samples in order to initiate testing.

For Trio/Critical Plus mt DNA analysis (1532, 1533): This test has two components (1600 and 2055 OR 1722 and 2055) which will be run CONCURRENTLY and reported separately when each test is completed. Turnaround time for the mitochondrial portion of testing is 50 days after financial responsibility has been verified (for 1532). Proband mitochondrial testing will proceed even if parental samples needed for Trio WES have not been received.

BIOLOGICAL PARENTS SAMPLES ARE REQUIRED FOR TRIO WES. Send 10 cc blood in an EDTA tube for each parental sample. Be sure to label parental samples with full name and date of birth of parent - DO NOT LABEL WITH CHILD'S NAME. Parents must sign parental testing authorization on consent.

1550: MOTHER (FULL NAME): _____ (LAST NAME) _____ (FIRST NAME) DOB: ___ / ___ / ___ (MM / DD / YY)

GENDER: FEMALE

☐ ASYMPTOMATIC ☐ SYMPTOMATIC (attach summary of findings) SAMPLE TYPE: ■ BLOOD DATE OF COLLECTION: ___ / ___ / ___ (MM / DD / YY)

1550: FATHER (FULL NAME): _____ (LAST NAME) _____ (FIRST NAME) DOB: ___ / ___ / ___ (MM / DD / YY)

GENDER: MALE

☐ ASYMPTOMATIC ☐ SYMPTOMATIC (attach summary of findings) SAMPLE TYPE: ■ BLOOD DATE OF COLLECTION: ___ / ___ / ___ (MM / DD / YY)

NOTE: Parental samples are the only acceptable samples, other family members CANNOT be substituted. Do not send samples from any other family members other than the biological parents.

LAST UPDATED: 7/2015

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TRIO WHOLE EXOME SEQUENCING REQUISITION

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

CHECKLIST OF ITEMS TO INCLUDE

- ☐ PROBAND SAMPLE (EDTA required)
- ☐ BIOLOGICAL MOTHER SAMPLE (EDTA required)
- ☐ BIOLOGICAL FATHER SAMPLE (EDTA required)
- ☐ REQUISITION
- ☐ CONSENT FORM SIGNED BY ALL INDIVIDUALS TESTED
- ☐ INDICATION FOR STUDY CHECK LIST
- ☐ CLINICAL NOTE/SUMMARY
- ☐ PEDIGREE

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 whole exome sequencing results. If the laboratory requires additional information, please indicate the health care provider to be contacted:

NAME: _____ PHONE/PAGER #: _____

	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	☐		☐	☐

INDICATIONS CONTINUED ON PAGE 3

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TRIO WHOLE EXOME SEQUENCING REQUISITION

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
Failure to thrive	☐		☐	☐
Structural brain abnormalities	☐		☐	☐
Eye anomalies	☐		☐	☐
Vision loss	☐		☐	☐
Congenital heart disease	☐		☐	☐
Kidney abnormalities	☐		☐	☐
Skeletal abnormalities	☐		☐	☐
Scoliosis	☐		☐	☐
Limb malformation	☐		☐	☐
Skin anomalies	☐		☐	☐
Genital anomalies	☐		☐	☐
Organomegaly	☐		☐	☐
Hemihypertrophy	☐		☐	☐
Cancer/tumor formation	☐		☐	☐
Family history of similar disorder	☐		☐	☐
Other	☐	_____	☐	☐

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TRIO WHOLE EXOME SEQUENCING REQUISITION

INFORMATION AND CONSENT FOR TESTING

Test order 1532 and 1533 in addition to trio WES analysis as detailed below will also include a separate analysis of the mitochondrial DNA. To learn more about this testing please visit our website, test code 2055 Comprehensive mtDNA Analysis by Massively Parallel Sequencing (MitoNGSSM). This is the evaluation of the entire mitochondrial genome for point mutations and deletions. The detection threshold of massively parallel sequencing analysis for heteroplasmic mitochondrial DNA point mutations is approximately 1.5%. This will be reported separately from the trio WES results with a turnaround time of 50 days.

Your physician has advised you (or your child) to undergo the genetic test called the Trio Whole Exome Sequencing (referred to as Trio WES). The purpose of this document is to provide information about the test. This information is meant to be used as a supplement to your discussion with your health care professional. If you agree to have the Trio WES test, you will be asked to sign the last page of this document, indicating that you understand the information provided and wish to have testing. You will be given a copy of this document for your records.

Description of Trio WES

The Trio WES test is a highly complex test that is newly developed for the identification of changes in an individual's DNA that are causative or related to their medical concerns. This test differs from other genetic tests in that the proband (or affected individual) is tested together with his or her parents and the results interpreted as a family. This approach to testing can be helpful in identifying genetic causes of a medical condition. Analyzing the data for changes that occur in the child, but not in the parents, can help to identify new mutations in genes that may be causative of you/your child's disease (de novo changes). In other cases, following the inheritance of changes from parent(s) to child can also aid in the identification of potentially causal disease genes. The exome refers to the portion of the human genome that contains functionally important sequences of DNA that direct the body to make proteins essential for the body to function properly. These regions of DNA are referred to as exons. It is known that most of the errors that occur in DNA sequences that then lead to genetic disorders are located in the exons. In contrast to current sequencing tests that analyze one gene or small groups of related genes at a time, the Trio Whole Exome Sequencing test will analyze the important regions of tens of thousands of genes at the same time. Therefore, sequencing of the exome is thought to be an efficient method of analyzing a patient's DNA to discover the genetic cause of diseases or disabilities. However, it is possible that even if the Trio WES identifies the underlying genetic cause for the disorder in your family this information may not help in predicting prognosis or change medical management or treatment of disease.

Indications for Testing

The decision to undergo the Trio Whole Exome Sequencing test is made by you and your physician. In general, the test is used when your medical history and physical exam findings strongly suggest that there is a genetic cause for your medical issues. The test requires 5-10 cc (about 1-2 teaspoon) of whole blood. You should expect that results of the Trio WES test will be sent to your physician in 10 weeks (test code 1600). Critical Trio WES (test code 1722) should be considered for patients who are critically ill or otherwise need rapid turnaround time of 3 weeks.

Test Reporting

When your exome sequence is compared to a normal reference sequence, many variations or differences are expected to be found. Based on currently available information in the medical literature and in scientific databases, we will decide whether any of these variations are predicted to be causative or related to your medical condition.

The report will contain results that may explain the cause of your current medical problems. It may also contain information on genes and diseases that have clear and immediate medical significance to your health or the health of family members, whether or not they relate to your current symptoms. As part of the Trio WES analysis, we will report findings in genes that have occurred in the affected individual, but not in the asymptomatic parents. This category of results caused by de novo findings, may be significant in determining the cause of the you/your child's medical condition. Thus, this category of changes will be reported for genes with or without a known current association with disease. We will also report compound heterozygous or homozygous variants in genes where each parent has one change and the affected individual has inherited both changes, for genes with or without a known association with disease. It is important to note that the Trio WES report may contain information on diseases and genes that do not relate to your current condition, or may develop many years from now, or do not have any known link to disease, according to current knowledge.

In addition it may also contain information in the following categories:

Category I: Medically Actionable

The report may also contain information on genes and diseases that are considered medically actionable because they have clear and immediate medical significance to your health or the health of family members, whether or not they relate to your current symptoms. The American College of Medical Genetics (ACMG) has published guidelines for the reporting of these types of medically actionable or incidental findings (PMID: 23788249). These guidelines include a list of genes, which may be updated periodically, that have been determined to be considered medically actionable and therefore laboratories should seek and report pathogenic variants in these genes. In accordance with an update to this policy statement (ACMG.net), there is the option to opt out of receiving pathogenic variants information if identified in the genes listed in ACMG policy statement.

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TRIO WHOLE EXOME SEQUENCING REQUISITION

INFORMATION AND CONSENT FOR TESTING (cont.)

Category II: Carrier Status
Carrier status for autosomal recessive conditions will include disorders recommended for reproductive screening by professional societies such as ACMG or ACOG (such as cystic fibrosis and Tay-Sachs disease, see FAQ on our website for a complete list).

See below for options regarding receipt of certain categories of results in the report.

Because medical information continues to advance, it is important to know that the interpretation of the variants is based on information available at the time of testing and may change in the future. As determined necessary by the laboratory the patient's sample will have certain findings confirmed by a second methodology (Sanger sequencing).

Report Exclusions: The report will not include findings in genes causing adult onset dementia syndromes for which there is presently no prevention or cure. If the proband has a phenotype that clearly indicates such a disorder we recommend pursuing targeted testing based on phenotype and not Trio WES testing. However, please note that if the patients has a clinical presentation that could indicate such a disorder or a mixed neurological phenotype then results may be returned for genes that have an allelic association with dementia or dementia is a component of the phenotype will then be reported in the proband and the parents.

We expect to find hundreds of variations when comparing the DNA to the reference sequence, most of these do not relate to disease and therefore will not be reported. The raw sequence data generated by the Trio WES is available for request once a Trio WES report has been issued. Please see our website for further information regarding this.

Requirement for Parental Samples
As part of the Trio WES test, blood samples from the biological parents of the proband are required. Trio Whole exome sequencing (Trio WES) will be performed on the proband and parental samples concurrently and the sequence data will be analyzed in the context of the family relationships.

The parental data will be used to help interpret the proband's data. A separate parental report will be issued regarding two categories of incidental findings. See the following pages for options regarding receipt of certain categories of results in the report, and see the previous sections “medically actionable” and “carrier status” for descriptions of these two categories.

Potential Risks and Discomforts
(1) It is possible that you could have a variant in a gene included in the Trio WES test, but the Trio WES test was unable to detect the variant. Therefore, it is possible that you may be affected with one of the conditions tested by Trio WES, but that the test did not detect the condition.
(2) The Trio WES test does not analyze 100% of the genes in the human genome. There are some genes that cannot be included in the test due to technical reasons.
(3) Results may be unclear or indicate the need for further testing on other family members.
(4) It is possible that additional information may come to light during these studies regarding family relationships. For example, data may suggest that family relationships are not as reported, such as non-paternity (the father of the individual is not the biological father) or consanguinity (marriage or reproductive partners are blood relatives). Since the accurate assignment of family relationships is critical to the analysis of the Trio WES, we will perform a separate genetic test to confirm that the samples that were submitted from the parents were correctly identified. If a discrepancy is identified, you will be notified through your physician and the Trio WES testing will be cancelled.
(5) If you sign the consent form, but you no longer wish to have your sample tested by Trio WES, you can contact your doctor to cancel the test. If testing is complete, but you have not received your results yet, you can inform your doctor that you no longer wish to receive the results. However, if you withdraw consent for testing after 5 p.m. the next business from the day of sample receipt by the laboratory, you will be charged for the full cost of the test.
(6) The cumulative results of Trio WES testing on many samples may be published in the medical literature. These publications will not include any information that will identify you personally.
(7) Due to the fact that many different genes and conditions are being analyzed, there is a risk that you will learn genetic information about yourself or your family that is not directly related to the reason for ordering the Trio WES. This information might relate to diseases with symptoms that may develop in the future in yourself or other family members as well as conditions that have no current treatment. If you have concerns about learning about other diseases unrelated to your current medical problems, please tell you doctor so that the results will not include this information.

Due to the complex nature of the Trio WES testing it is recommended that families seek genetic counseling in conjunction with testing.

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INFORMATION AND CONSENT FOR TESTING (cont.)

PROBAND REPORTING OPTIONS AND AUTHORIZATION

Please read the below statements carefully and check the appropriate box and initial. Due to the nature of the methodology of this testing we are unable to guarantee that all pathogenic variants in each option will be detected by the Trio WES testing. For TRIO WES (test code 1600) this information will be incorporated into your TRIO WES report. For Critical Trio WES (test code 1722) this will be an additional report with a turnaround time of up to 10 weeks.

For options 1 & 2 below: if neither box is checked the lab will default to the NO/ do NOT report option.

1. Medically Actionable

Initial

Pathogenic variants in genes included in the ACMG policy statement regarding recommendations for reporting of incidental findings will be reported as medically actionable on the Trio WES report.

_____ ☐ YES: please report pathogenic variants in genes determined to be medically actionable by the ACMG policy statement.

_____ ☐ NO: please do NOT report pathogenic variants in genes included in the ACMG policy statement.

Initial 2. Carrier Status for Autosomal Recessive Conditions Recommended for Reproductive Carrier Screening

_____ ☐ YES: please report carrier status. By checking this box, I choose to receive information regarding carrier status.

_____ ☐ NO: please do NOT report carrier status. By checking this box, I choose to NOT receive information regarding carrier status.

For option 3: if neither box is checked the lab will default to the YES/ release updated report option.

3. Option to allow release of updated results

We may periodically review old cases when new information is learned regarding the significance of changes in a particular gene. If a possible diagnosis can be made with this information we would like to issue an updated report to the physician who ordered your Trio WES test. The current schedule for this review is every six months, but is subject to change and does NOT include a complete review of all of your data.

Initial

_____ ☐ YES: if new information is known regarding clinical significance of information that may not have previously been included in my Trio WES report I would like for you to issue an updated report to my physician who ordered this Trio WES testing.

_____ ☐ NO: please do NOT issue an updated report if there is new information regarding the clinical significance of my Trio WES data that may not have been previously reported.

I hereby authorize Baylor Miraca Genetics Laboratories to conduct genetic testing for myself (or my child) for the Trio Whole Exome Sequencing test (Trio WES) as recommended by my physician.

Signature: _____ Date: _____

Printed Name: _____

Patient Name: _____ Patient DOB (MM/DD/YY): _____

Relationship to Patient: _____

Physician's/Counselor's Signature: _____ Date: _____

For Samples Submitted From New York State

Specimen Retention: My sample shall be destroyed at the end of the testing process or not more than 60 days after completion of testing. However, I hereby authorize the lab to retain my sample(s) for a longer retention in accordance to the laboratory retention policy for internal laboratory quality assurance studies and possible research testing.

_____
Initial

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TRIO WHOLE EXOME SEQUENCING REQUISITION

INFORMATION AND CONSENT FOR TESTING (cont.)

PARENT REPORTING OPTIONS AND AUTHORIZATION

Confirmation of Parentage:

I understand that the accurate assignment of family relationships is critical to the analysis of the Trio WES, therefore the laboratory will perform a separate genetic test to confirm that the samples that were submitted from the parents and child were correctly identified. If a discrepancy is identified, you will be notified through your physician and the Trio WES testing will be cancelled.

_____ Mother's Initials _____ Father's Initials

We hereby authorize Baylor Miraca Genetics Laboratories to conduct genetic testing on our samples (biological parents) for the purposes of clarifying results for the Trio Whole Exome Sequencing test (Trio WES) that is being performed on our child's blood sample as recommended by our child's physician. We understand that our samples will be subjected to Trio WES, and will be analyzed to help interpret the sequence data of our child. A separate parental report will be issued regarding the below two categories of incidental findings. It may be possible to infer information about family member's results based on the proband's or other family member's results. Turnaround time to receive this report is 10 weeks.

MOTHER

Please read the below statements carefully and check the appropriate box and initial. Due to the nature of the methodology of this testing we are unable to guarantee that all pathogenic variants in each option will be detected by the Trio WES testing.

For options 1 & 2 below: if neither box is checked the lab will default to the NO/ do NOT report option.

1. Medically Actionable

Initial

Pathogenic variants in genes included in the ACMG policy statement regarding recommendations for reporting of incidental findings will be reported as medically actionable on the Trio WES report.

_____ ☐ YES: please report pathogenic variants in genes determined to be medically actionable by the ACMG policy statement.

_____ ☐ NO: please do NOT report pathogenic variants in genes included in the ACMG policy statement.

Initial 2. Carrier Status for Autosomal Recessive Conditions Recommended for Reproductive Carrier Screening

_____ ☐ YES: please report carrier status. By checking this box, I choose to receive information regarding carrier status.

_____ ☐ NO: please do NOT report carrier status. By checking this box, I choose to NOT receive information regarding carrier status.

Mother's Signature: _____ Date: _____

Printed Name: _____ DOB (MM/DD/YY): _____

For Samples Submitted From New York State

Specimen Retention: My sample shall be destroyed at the end of the testing process or not more than 60 days after completion of testing. However, I hereby authorize the lab to retain my sample(s) for a longer retention in accordance to the laboratory retention policy for internal laboratory quality assurance studies and possible research testing.

Initial

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TRIO WHOLE EXOME SEQUENCING REQUISITION

INFORMATION AND CONSENT FOR TESTING (cont.)

FATHER

Please read the below statements carefully and check the appropriate box and initial. Due to the nature of the methodology of this testing we are unable to guarantee that all pathogenic variants in each option will be detected by the Trio WES testing.

For options 1 & 2 below: if neither box is checked the lab will default to the NO/ do NOT report option.

1. Medically Actionable

Initial

Pathogenic variants in genes included in the ACMG policy statement regarding recommendations for reporting of incidental findings will be reported as medically actionable on the Trio WES report.

_____ ☐ YES: please report pathogenic variants in genes determined to be medically actionable by the ACMG policy statement.

_____ ☐ NO: please do NOT report pathogenic variants in genes included in the ACMG policy statement.

Initial 2. Carrier Status for Autosomal Recessive Conditions Recommended for Reproductive Carrier Screening

_____ ☐ YES: please report carrier status. By checking this box, I choose to receive information regarding carrier status.

_____ ☐ NO: please do NOT report carrier status. By checking this box, I choose to NOT receive information regarding carrier status.

Father's Signature: _____ Date: _____

Printed Name: _____ DOB (MM/DD/YY): _____

For Samples Submitted From New York State

Specimen Retention: My sample shall be destroyed at the end of the testing process or not more than 60 days after completion of testing. However, I hereby authorize the lab to retain my sample(s) for a longer retention in accordance to the laboratory retention policy for internal laboratory quality assurance studies and possible research testing.

_____
Initial

SEE NEXT PAGE FOR POTENTIAL RESEARCH OPPORTUNITY

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Additional Studies- RESEARCH

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 a Baylor College of Medicine 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 and contact information MUST be completed, or we will not be able to reach you regarding these opportunities.

Authorization:

Signature: _____ Date: _____

Printed Name: _____

Patient Name: _____ DOB (MM/DD/YY): _____ 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.

_____ Initial ☐ YES, Baylor Miraca Genetics Laboratories may contact my/my child's doctor who ordered the Trio WES test to discuss research studies that I/my child may be eligible for. There is no obligation to participate if contacted. If choosing YES, please make sure that the "Authorization" section above is completed.

PHYSICIAN WHO ORDERED TRIO WES - CONTACT INFORMATION:

Last Name: _____ First Name: _____

Phone #: _____ FAX #: _____

Address: _____ _____ _____ _____
City State Zip Code

_____ Initial ☐ NO, I DO NOT want my/my child's doctor contacted regarding 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 (NOTE: THIS OPTION IS PAYMENT OPTION IS NOT AVAILABLE FOR 1722 CRITICAL TRIO WES)

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): _____