BAYLOR GENETICS
READY WITH ANSWERS

SHIPPING Baylor Genetics
2450 Holcombe Blvd., Grand Blvd. Receiving Dock
Houston, TX 77021-2024
Phone: 713.798.6555
Fax: 713.798.2787

CUSTOM REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM/DD/YY)

Address | Accession # | Hospital/ Medical Record #

Biological Sex: ◯ M ◯ F ◯ Unknown

City | State | Zip | Phone | Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

◆ **ADDITIONAL RECIPIENTS**

Name | Name

Email | Fax | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

☐ **SELF PAYMENT**

◯ Bill Patient For Laboratory Testing

☐ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

☐ **INSURANCE**

☐ Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS
1. Copy of the Front/Back of Insurance Card(s)
2. ICD10 Diagnosis Code(s)
3. Name of Ordering Physician
4. Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM/DD/YY) | Address of Insured

Patient's Relationship to Insured | Phone of Insured | City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone | Primary Member Policy # | Primary Member Group #

Secondary Insurance Co. Name | Secondary Insurance Co. Phone | Secondary Member Policy # | Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my designated insurance carrier any information necessary, including test results, for processing my insurance claim. I also authorize benefits to be payable exclusively to Baylor Genetics. I understand that my insurance carrier may not approve or reimburse my medical genetic services in full or any portion thereof, due to a variety of reasons, including, but not limited to: the contract status of my insurance provider with Baylor Genetics, usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. I understand that I am responsible for any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Name | Patient's Signature | Date

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name | Physician's Signature | Date

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ETHNICITY

- ◯ African American
- ◯ Ashkenazi Jewish
- ◯ East Asian (China, Japan, Korea)
- ◯ Finnish
- ◯ French Canadian
- ◯ Hispanic American
- ◯ Mennonite
- ◯ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- ◯ Native American
- ◯ Northern European Caucasian (Scandinavian, UK, Germany)
- ◯ Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- ◯ South Asian (India, Pakistan)
- ◯ Southeast Asian (Vietnam, Cambodia, Thailand)
- ◯ Southern European Caucasian (Spain, Italy, Greece)
- ◯ Other (Specify) _____

INDICATION FOR TESTING (REQUIRED)

☐ Symptomatic (Summarize below)

☐ Symptomatic with Positive Family History

☐ Asymptomatic

- ◯ Population Screening
- ◯ Positive Family History

Disease _____ Gene _____ Variant _____

ICD10 Diagnosis Code(s) _____

SAMPLE

_____ / _____ / _____
Date of Collection (MM/DD/YY)

◆ **SAMPLE TYPE**

- ◯ Blood
- ◯ Cord Blood
- ◯ Saliva
- ◯ Skeletal Muscle
- ◯ DNA (Specify) _____
- ◯ Other (Specify) _____

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

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INDICATION FOR TESTING (REQUIRED)

☐ Clinical management of known diagnosis - Please specify: _____

☐ Diagnostic Testing - Please complete checklist 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	pan	Pancreatitis
◯ 117	dia	Diarrhea
◯ 118	cst	Constipation
◯ 119	cv	Cyclic Vomiting
◯ 120	pob	Pseudoobstruction

◆ 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
◯ 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

◆ ELECTROPHYSIOLOGY

◯ 801	baers	Abnormal BAERS
◯ 802	vers	Abnormal VERS
◯ 803	eeg	Abnormal EEG

◆ 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
◯ 608	adc	Adrenal Calcification
◯ 609	hf	Hydrops Fetalis
◯ 610	pg	Pregnant

◆ 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

◆ 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

◆ 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	Hypoammonemia
◯ 413	hypo	Hypoglycemia
◯ 414	hyper	Hyperglycemia
◯ 415	uco	Unusual Color/Odor

◆ MUSCLE BIOPSY

◯ 901	his	Abnormal Histology
◯ 902	em	Abnormal Ultrastructure
◯ 903	enz	Abnormal Respiratory Enzymes
◯ 904	prol	Large Mitochondria/Proliferation
◯ 905	cox	COX Deficiency
◯ 906	rrf	Ragged Red Fibers

◆ HAIR/SKIN FINDINGS

◯ 714	rash	Rashes with Hypopigmentation
◯ 715	htii	Hyper Trichosis
◯ 716	alp	Alopecia
◯ 717	ac	Acrocyanosis
◯ 718	ak	Angiokeratoma
◯ 719	ic	Ichthyosis

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◆ FAMILY HISTORY

◯ 001	mut	Mutation (Attach details)
◯ 002	mi	Evidence of Maternal Inheritance

◆ OTHER CLINICAL

◯ 701	ftt	Failure to Thrive
◯ 702	mce	Microencephaly
◯ 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