

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 #	
City		State	Zip	Phone	Biological Sex: <input type="radio"/> M <input type="radio"/> F <input type="radio"/> Unknown
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
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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
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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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CUSTOM REQUISITION

ETHNICITY

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

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

CUSTOM REQUISITION

INDICATION FOR TESTING (REQUIRED)

- Clinical management of known diagnosis - Please specify: _____
- Diagnostic Testing - Please complete checklist below.

◆ CENTRAL NERVOUS SYSTEM

<input type="radio"/> 101	dd	Developmental Delay/ ID
<input type="radio"/> 102	ht	Hypotonia
<input type="radio"/> 103	au	Autistic Features
<input type="radio"/> 104	enc	Dementia/ Encephalopathy
<input type="radio"/> 105	ha	Headaches/ Migraines
<input type="radio"/> 106	stk	Stroke, Ischemic Episodes
<input type="radio"/> 107	atx	Ataxia
<input type="radio"/> 108	sz	Intractable/ Refractory/Myoclonus/ Myoclonic Seizures
<input type="radio"/> 109	pi	Perinatal Insult
<input type="radio"/> 110	ps	Pyramidal Signs
<input type="radio"/> 111	hp	Hemiparesis
<input type="radio"/> 112	spas	Spasticity
<input type="radio"/> 113	dyst	Dystonia
<input type="radio"/> 114	cho	Chorea
<input type="radio"/> 115	sib	Self-Injury
<input type="radio"/> 116	pan	Pancreatitis
<input type="radio"/> 117	dia	Diarrhea
<input type="radio"/> 118	cst	Constipation
<input type="radio"/> 119	cv	Cyclic Vomiting
<input type="radio"/> 120	pob	Pseudoobstruction

◆ VISCERAL

<input type="radio"/> 301	gir	Gastrointestinal Reflux
<input type="radio"/> 302	dge	Delayed Gastric Emptying
<input type="radio"/> 303	pan	Pancreatitis
<input type="radio"/> 304	dia	Diarrhea
<input type="radio"/> 305	cst	Constipation
<input type="radio"/> 306	cv	Cyclic Vomiting
<input type="radio"/> 307	pob	Pseudoobstruction
<input type="radio"/> 308	hpf	Hepatic Failure
<input type="radio"/> 309	eta	Elevated Transaminases
<input type="radio"/> 310	rtd	Renal Tubular Disease
<input type="radio"/> 311	ap	Apnea/ Hypoventilation
<input type="radio"/> 312	rsf	Respiratory Deficiency/Failure
<input type="radio"/> 313	ren	Renal Dysfunction
<input type="radio"/> 314	lc	Liver Carcinoma
<input type="radio"/> 315	jau	Jaundice
<input type="radio"/> 316	spm	Splenomegaly/Enlarged Spleen
<input type="radio"/> 317	hpm	Hepatomegaly/Enlarged Liver
<input type="radio"/> 318	hd	Hepatic Dysfunction

◆ ELECTROPHYSIOLOGY

<input type="radio"/> 801	baers	Abnormal BAERS
<input type="radio"/> 802	vers	Abnormal VERS
<input type="radio"/> 803	eeg	Abnormal EEG

◆ SENSORY

<input type="radio"/> 501	rp	Retinitis Pigmentosa
<input type="radio"/> 502	opa	Optic Atrophy
<input type="radio"/> 503	cat	Cataract
<input type="radio"/> 504	hl	Sensorineural Hearing Loss
<input type="radio"/> 505	trv	Tortuous Retinal Vessels
<input type="radio"/> 506	crs	Cherry Red Spot/Eye
<input type="radio"/> 507	co	Corneal Opacity
<input type="radio"/> 508	el	Ectopia Lentis
<input type="radio"/> 509	pp	Photophobia

◆ ENDOCRINE

<input type="radio"/> 601	db	Diabetes
<input type="radio"/> 602	pd	Exocrine/Pancreatic Deficiency
<input type="radio"/> 603	gf	Gonadal Failure
<input type="radio"/> 604	hth	Hypothyroidism
<input type="radio"/> 605	hpt	Hypoparathyroidism
<input type="radio"/> 606	adr	Hypo/Hyper-adrenal Function
<input type="radio"/> 607	ss	Short Stature
<input type="radio"/> 608	adc	Adrenal Calcification
<input type="radio"/> 609	hf	Hydrops Fetalis
<input type="radio"/> 610	pg	Pregnant

◆ NEUROMUSCULAR

<input type="radio"/> 201	pn	Peripheral Neuropathy
<input type="radio"/> 202	exi	Exercise Intolerance
<input type="radio"/> 203	pmw	Progressive Muscle Weakness
<input type="radio"/> 204	smw	Static Muscle Weakness
<input type="radio"/> 205	cr	Muscle Cramps after Exercise
<input type="radio"/> 206	fat	Easy Fatigability
<input type="radio"/> 207	dcmo	Dilated Cardiomyopathy
<input type="radio"/> 208	hcmo	Hypertrophic Cardiomyopathy
<input type="radio"/> 209	hb	Heart Block
<input type="radio"/> 210	ar	Arrhythmia
<input type="radio"/> 211	op	Ophthalmoparesis, CPEO
<input type="radio"/> 212	emg	Abnormal EMG/NCV
<input type="radio"/> 213	pto	Ptosis
<input type="radio"/> 214	eh	Cardiomegaly/Enlarged Heart

◆ IMAGING/OTHER STUDIES

<input type="radio"/> 804	bg	Increased Signal Basal Ganglia
<input type="radio"/> 805	dmy	Delayed Myelination
<input type="radio"/> 806	cea	Cerebellar Atrophy
<input type="radio"/> 807	pstk	Posterior Stroke
<input type="radio"/> 808	leuk	Leukodystrophy
<input type="radio"/> 809	mrsi	MRS/Lactate Peak
<input type="radio"/> 810	mri	Abnormal MRI

◆ METABOLITES / METABOLIC

<input type="radio"/> 400	nbs	Abnormal Newborn Screen
<input type="radio"/> 401	kto	Ketosis
<input type="radio"/> 402	dca	Dicarboxylic Aciduria
<input type="radio"/> 403	la	Lactic Acidosis
<input type="radio"/> 404	csfl	High CSF Lactate
<input type="radio"/> 405	oa	Organic Aciduria
<input type="radio"/> 406	lpc	Low Plasma Carnitine
<input type="radio"/> 407	cpk	CPK Abnormalities
<input type="radio"/> 408	pyr	Elevated Pyruvate
<input type="radio"/> 409	ala	Elevated Alanine
<input type="radio"/> 410	3mg	3-Methylglutaconic Aciduria
<input type="radio"/> 411	acid	Acidosis
<input type="radio"/> 412	NH3	Hypoammonemia
<input type="radio"/> 413	hypo	Hypoglycemia
<input type="radio"/> 414	hyper	Hyperglycemia
<input type="radio"/> 415	uco	Unusual Color/Odor

◆ MUSCLE BIOPSY

<input type="radio"/> 901	his	Abnormal Histology
<input type="radio"/> 902	em	Abnormal Ultrastructure
<input type="radio"/> 903	enz	Abnormal Respiratory Enzymes
<input type="radio"/> 904	prol	Large Mitochondria/Proliferation
<input type="radio"/> 905	cox	COX Deficiency
<input type="radio"/> 906	rrf	Ragged Red Fibers

◆ HAIR/SKIN FINDINGS

<input type="radio"/> 714	rash	Rashes with Hypopigmentation
<input type="radio"/> 715	htii	Hyper Trichosis
<input type="radio"/> 716	alp	Alopecia
<input type="radio"/> 717	ac	Acrocyanosis
<input type="radio"/> 718	ak	Angiokeratoma
<input type="radio"/> 719	ic	Ichthyosis

CUSTOM REQUISITION**◆ FAMILY HISTORY** _____

<input type="radio"/> 001	mut	Mutation (Attach details)
<input type="radio"/> 002	mi	Evidence of Maternal Inheritance

◆ OTHER CLINICAL _____

<input type="radio"/> 701	ftt	Failure to Thrive
<input type="radio"/> 702	mce	Microencephaly
<input type="radio"/> 703	sids	SIDS/Unexplained Death
<input type="radio"/> 704	ca	Congenital Anomalies
<input type="radio"/> 705	dys	Dysmorphic Features
<input type="radio"/> 706	id	Immunodeficiency
<input type="radio"/> 707	ma	Macrocytic Anemia
<input type="radio"/> 708	pcbm	Pancytopenia/Bone Marrow Failure
<input type="radio"/> 709	np	Neutropenia
<input type="radio"/> 710	mc	Macrocephaly
<input type="radio"/> 711	cf	Course Features
<input type="radio"/> 712	sa	Skeletal Anomalies
<input type="radio"/> 713	art	Arthritis