Integrated GENETICS
LabCorp Specialty Testing Group

MOLECULAR GENETICS TEST REQUISITION

Highlighted fields are required.

Patient Information

Name
Last First MI

☐ Male ☐ Female Date of Birth / /

Address

Home Phone Work Phone

City State Zip

Lab # Hospital #

Client Information

I attest that this patient has been informed about and has given consent for the test(s) I have ordered below under applicable law.

Referring Physician (print):

Physician/Authorized Signature:

Genetic Counselor (print):

NPI#: Taxonomy#:

Laboratory Tests Ordered

Ashkenazi Jewish Testing (may be appropriate for other ethnicities)

☐ Check here for all Ashkenazi Jewish Tests or check separately

562 ☐ Bloom syndrome*
554 ☐ Canavan disease*
530 ☐ CF*plus*® (97 mutation test)*†
519 ☐ Dihydrolipoamide dehydrogenase deficiency*
207 ☐ Familial dysautonomia*
585 ☐ Familial hyperinsulinism*
534 ☐ Fanconi anemia (Group C)*
595 ☐ Gaucher disease*
522 ☐ Glycogen storage disease type 1a*
501 ☐ Joubert syndrome 2*
518 ☐ Maple syrup urine disease*
573 ☐ Mucolipidosis type IV*
587 ☐ Nemaline myopathy*
557 ☐ Niemann-Pick (type A)*
350 ☐ Tay-Sachs enzymes only
593 ☐ Tay-Sachs enzymes and DNA*
589 ☐ Usher syndrome type IF*
599 ☐ Usher syndrome type III*
502 ☐ Walker-Warburg syndrome*

Pan Ethnic Testing

Inheritest® Carrier Screen on NGS (includes SMA, CFplus, and Fragile X*†)**

451950 ☐ Comprehensive (142 genes)***† **451960** ☐ Society Guided (12 genes)***†
451920 ☐ Ashkenazi Jewish Panel (39 genes)***†

Inheritest® Carrier Screen by Array

540 ☐ Inheritest® Carrier Screen† **541** ☐ Inheritest® Select Carrier Screen†

☐ Check here for all single gene tests listed below or check separately

530 ☐ CF*plus*® (97 mutation test)*†
523 ☐ Fragile X Carrier Screen (no family history, PCR only)†
516 ☐ Spinal muscular atrophy (SMA) Both parents' bloods required for prenatal dx*†
☐ Mutation Specific Sequencing (call before sending)
☐ Gene Specific Sequencing (call before sending)

Required: Gene(s): _____
Mutation(s): _____

Other Tests

565 ☐ Angelman syndrome/Prader Willi syndrome - methylation
521 ☐ Fragile X Dx Test (symptomatic/family history, PCR & Southern blot)*
582 ☐ Full cystic fibrosis gene sequencing**
528 ☐ Maternal cell contamination (MCC) analysis*
538 ☐ Poly (T) testing for CFTR Intron 8
591 ☐ Y chromosome microdeletion analysis

Thrombophilia

548 ☐ Factor V (Leiden)
526 ☐ MTHFR (C677T)
549 ☐ Factor II (prothrombin G20210A)
☐ Other _____

*Call before sending if for Fetal DNA. Maternal cell contamination analysis required for all prenatal dx (send a maternal sample).
**Call laboratory before sending. ***Fragile X is females only

Date drawn: / /

Pregnancy: ☐ Yes ☐ No Gravida:_____ Para:_____ Gestation _____ Wks

Specimen Type (Check one):

Parental ☐ Peripheral Blood ☐ Mouthwash ☐ Guthrie Card
Fetal ☐ Fetal Blood ☐ Amniotic Fluid ☐ Chorionic Villi ☐ POC
Back-up culture by: ☐ Integrated Genetics ☐ Other _____ Hold for:_____

Ethnicities (Check all that apply):

☐ Caucasian ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Asian ☐ African American
☐ Native American ☐ Hispanic ☐ Other: _____

Hereditary Breast and Ovarian Cancer (clinical questionnaire required, components on back)

☐ BRCA*ssure*®: Comprehensive Analysis
☐ BRCA*ssure*®: BRCA1 Targeted Analysis
☐ BRCA*ssure*®: BRCA2 Targeted Analysis
☐ BRCA*ssure*®: Ashkenazi Jewish Panel
☐ BRCA*ssure*®: BRCA1/2 Deletion/Duplication Analysis

Hereditary Cancer Panel (clinical questionnaire required, genes listed on back)

☐ VistaSeq℠ Hereditary Cancer Panel (27 Gene Assay)
☐ VistaSeq℠ Hereditary Cancer Panel without *BRCA1/2* genes (25 Gene Assay)

All diagnoses should be provided by the ordering physician or an authorized designee. Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

ICD-CM		ICD-CM		ICD-CM	

Indication(s) for Test (check all that apply)

Diagnostic: ☐ Known affected_____
☐ Symptoms _____
☐ Congenital absence of vas deferens
☐ Azoospermia ☐ Oligospermia
☐ Infertility
☐ Thrombophilia
☐ Other Indication: _____

Clinical History

Carrier: ☐ No family history (screening)
☐ Family history : relative _____
☐ Abnormal fetal ultrasound : specify _____
☐ Egg donor ☐ Sperm donor
☐ Known carrier : specify _____

Fetal: ☐ Family history : specify _____
☐ Abnormal fetal ultrasound : specify _____

†Reflex policy: The following will be performed by reflex at additional charge: **CFTR Intron 8 poly(T)** when R117H CF mutation is present; **Southern blot analysis** when Fragile X PCR shows >54 CGG repeats; **SMN2 analysis** when SMN1 indicates 0 copies.

BILLING INFORMATION

Patient Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital
☐ Medicaid ☐ Medicare ☐ Insurance ☐ Client Bill ☐ CA XAFP ☐ Self-Pay
☐ Billing Information Attached (Please include a copy of insurance card or face sheet.)
Do not attach credit card information to this form for security purposes.

Insurance Company Name _____
Policy # _____ Group # _____
Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Patient Signature _____ Date: _____

INTEGRATED GENETICS INTERNAL USE ONLY

By signing this form, I hereby authorize Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to LCAH.
I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

Informed Consent/Refusal for Genetic Testing

DNA Testing

1. The purpose of my DNA test is to look for mutation(s) or genetic alterations known to be associated with the following genetic condition or disease: _____

   _____

   _____

   _____ .

2. This testing is done on a small sample of blood.

3. Mutations and alterations are often different in different populations. I understand that the laboratory needs accurate information about my family history and ethnic background for the most accurate interpretation of the test results.

4. When DNA testing shows a mutation or alteration, then the person is a carrier or is affected with that condition or disease or, in the case of cancer genetic testing, the person is a carrier of a mutation or alteration that may be associated with an increased risk for certain cancer(s) compared to the general population. Consulting a doctor or genetic counselor is recommended to learn the full meaning of the results and to learn if additional testing might be necessary.

5. When the DNA testing does not show a known mutation or alteration, the chance that the person is a carrier or is affected is reduced, or, in the case of cancer genetic testing, the person's risk for certain cancer(s) compared to the general population will depend on additional personal factors. There is still a chance to be a carrier or to be affected because the current testing cannot find all the possible changes within a gene.

6. In some families DNA testing might discover non-paternity (someone who is not the biological father), or some other previously unknown information about family relationships, such as adoption.

7. The decision to consent to, or to refuse the above testing is entirely mine.

8. No test(s) will be performed and reported on my sample other than the one(s) authorized by my doctor, and any unused portion of my original sample will be destroyed within 60 days of receipt of the sample by the laboratory.

9. Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies will disclose the test results ONLY to the doctor named below, or to his/her agent, unless otherwise authorized by the patient or required by law.

10. My signature below indicates that I have read, or had read to me, the above information and I understand it. I have also read or had explained to me the specific disease(s) or condition(s) tested for, and the specific test(s) I am having, including the test descriptions, principles, and limitations. I have had the opportunity to discuss the purposes and possible risks of this testing with my doctor or someone my doctor has designated. I know that genetic counseling is available to me before and after the testing. I have all the information I want and all my questions have been answered.

YES: I REQUEST that Dr. _____ perform the genetic testing above. I understand and accept the consequences of this decision.

_____ _____ _____

Patient Signature | Date | Obtained by

NO: I DECLINE to have the genetic testing offered to me. I understand and accept the consequences of this decision.

_____ _____ _____

Patient Signature | Date | Obtained by

California, Georgia, New York, and Utah have statutes requiring laboratories to send confidential results of certain genetic tests to state or federal health agencies for monitoring the detection of birth defects.

It is standard of care for physicians to obtain informed consent for genetic testing. This model consent form is designed to address the requirements of New York State Civil Rights Law Section 79-L and Massacusetts General Law Chapter 111, Section 70G. Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies require that all reproductive genetic testing sent to any of our laboratories be accompanied by the signed attestation on the front of this Test Requisition Form. Relevant educational materials are also available through LCAH.

BRCA*ssure*® Test Components	Comprehensive *BRCA1/2* Analysis: Includes full gene sequencing and duplication/deletion testing of *BRCA1/2* genes	*BRCA1* or *BRCA2* Targeted Sequencing: Includes sequencing of known familial mutation (one gene Exon only)	Ashkenazi Jewish *BRCA* Panel: Includes screening for three known pathogenic variants; two in *BRCA1* gene, one in *BRCA2* gene

VistaSeq℠ Hereditary Cancer Panel Gene List

APC	CDH1	MSH2	PTEN
ATM	CDK4	MSH6	RAD51C
BARD1	CDKN2A	MUTYH	RAD51D
BMPR1A	CHEK2	NBN	SMAD4
BRCA1	EPCAM	PALB2	STK11
BRCA2	FAM175A	PMS2	TP53
BRIP1	MLH1	PRKAR1A	

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