Shodair Children's Hospital Genetics Laboratory
2755 Colonial Dr, Helena. MT, 59601
Phone (406) 444-7532 Toll Free (800) 447-6614
Fax (406) 444-1022

Shodair Lab Number

GENETICS LABORATORY WHOLE EXOME SEQUENCING TEST REQUEST FORM

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____

DOB: _____ **Sex:** ☐ Female ☐ Male **Ethnicity** *select all that apply*:

❑ Caucasian ❑ Asian ❑ Hispanic ❑ African American ❑ Ashkenazi Jewish ❑ Hutterite ❑ American Indian ❑ Other _____

Address: _____

City, State, Zip: _____

Phone: _____ **Email**: _____

ORDERING HEALTH CARE PROFESSIONAL & AUTHORIZATION

Name: _____ **NPI #:** _____

Address: _____ **City, State, Zip:** _____

Telephone:(_____)_____ **Fax**:(_____)_____ **Referring Facility:**_____

Additional Reports To: _____

By submitting this requisition, I confirm that I have obtained the patient's informed consent for the requested test. I confirm that this test is clinically valuable for the patient. Please call us at 406-444-7532 for CPT codes and Estimated Cost of testing.

Signature of ordering provider: _____ **Date:** _____

PATIENT CONSENT

Please visit our website for the separate Informed Consent for WES that is required for each family member participating in Whole Exome Sequencing. If you would like a member of Shodair Genetics to discuss WES consent and testing with the patient, please contact us at 406-444-7532.

WHOLE EXOME SEQUENCING (WES)

❑ **Rapid Infant Exome** (*does **not** include analysis for secondary findings*)
- ❑ **Reflex to Full WES Trio** *(can opt-in to analysis for secondary findings)*

❑ **Whole Exome Sequencing** *(can opt-in to analysis for secondary findings)*

SAMPLE INFORMATION

❑ Whole Blood (≥3mL)
❑ Saliva/Buccal Cells
❑ Extracted DNA (≥10ug)
Source:_____

Date of Collection: _____
Reference # :_____

ADDITIONAL FAMILY SAMPLES (Whole Blood/Saliva) *family samples are required*

Name:_____ DOB:_____
Relationship:_____ Ref #:_____
Date Collected: _____ Affected: ☐ Yes ☐ No

Name:_____ DOB:_____
Relationship:_____ Ref #:_____
Date Collected: _____ Affected: ☐ Yes ☐ No

INSURANCE BILLING Please provide a copy of front & back of card

Name of policy holder: _____
Policy holder DOB: _____ **Relationship:** _____
Name of Ins. Co: _____
Ins. Co. Policy #: _____
Ins. Co Phone: _____

MEDICAID / MEDICARE

Name of policy holder: _____
Policy holder DOB: _____ **Medicaid/Medicare # :** _____
Passport ID: _____ **Phone**: _____
Address: _____
City, State, Zip: _____

PREAUTHORIZATION IS REQUIRED FOR WES

❑ **YES** Preauthorization completed & approved. **Please include a copy of the approval letter with this form**.

❑ **NO** Preauthorization has **not** been completed. **Please assist with preauthorization.** Please provide visit note for medical necessity, copy of front & back of insurance card, and demographics.

Please designate a contact for preauthorization updates:

Name:_____

Phone or email: _____

INSTITUTIONAL BILLING

Institution: _____
Address: _____
City, State, Zip: _____
Billing Contact: _____
Phone: _____ **Fax**: _____

Specific Test Instructions:

Shodair Internal Use Only:	Date Received	Tracking #	Sender	Initials