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 Assigned at Birth: □ Male □ Female □ _____ **Gender Identity:** □ Male □ Female □ Non-binary □ _____

Address: _____

City, State, Zip: _____

Phone: _____ **Email:** _____

Ethnicity (select all that apply):

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

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.

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 for Whole Exome Sequencing testing.

Last Name: _____ First Name: _____

DOB: _____ Relationship: _____

Affected: □ No □ Yes _____

Date of Collection: _____ Source: _____

Last Name: _____ First Name: _____

DOB: _____ Relationship: _____

Affected: □ No □ Yes _____

Date of Collection: _____ Source: _____

PREAUTHORIZATION IS REQUIRED FOR WHOLE EXOME SEQUENCING

Has preauthorization been completed?

❑ **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, ICD10, copy of front & back of insurance card, and demographics.

Please designate a contact for preauthorization updates:

Name:_____

Phone/email: _____

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: _____

INSTITUTIONAL BILLING

Institution: _____ **Address:** _____

City, State, Zip: _____ **Phone:** _____ **Fax:** _____

Billing Contact: _____

Received	Date Received	Tracking #	Sender	Initials

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 Name: _____ **DOB:** _____

REASON FOR TESTING, CLINICAL DIAGNOSIS AND ICD-10 CODES

Please include any additional clinical information (medical records, pictures, family history) to aid in result interpretation.

	Clinical Description:	Phenotypic Description:	ICD-10 Codes *(required)*:
❑ Diagnostic ❑ Prenatal ❑ Carrier Screening ❑ Family History ❑ No Family History			

WHOLE EXOME SEQUENCING (WES)

Acceptable sample: EDTA blood, cultured cells, fresh/frozen tissue

Specific Test Instructions:

❑ **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)*

ADDITIONAL CLINICAL INDICATIONS

Perinatal history
(Please check all the apply)
❑ Prematurity
❑ Intrauterine growth retardation
❑ Oligohydramnios
❑ Polyhydramnios
❑ Cystic hygroma / increased NT
❑ Shortened fetal long bones
❑ Choroid plexus cyst
❑ Ventriculomegaly
❑ Echogenic bowel
❑ Fetal pyelectasis/fetal renal pelvic dilatation
❑ Single umbilical artery (SUA)
❑ Maternal diabetes mellitus

Growth
❑ Failure to thrive
❑ Growth retardation / short stature
❑ Overgrowth
❑ Macrocephaly
❑ Microcephaly

Physical/Cognitive Development
❑ Fine motor delay
❑ Gross motor delay
❑ Speech delay
❑ Intellectual disability
❑ Learning disability
❑ Developmental regression

Skin, Hair, & Nail Abnormalities
❑ Nails: _____
❑ Pigmentation:_____
❑ Connective tissue: _____
❑ Blistering
❑ Ichthyosis
❑ Skin tumors/Malignancies
❑ Other: _____

Craniofacial/Ophthalmologic/Auditory
❑ Cataracts
❑ Cleft lip/palate
❑ Coloboma of eye
❑ CPEO (ophthalmoplegia)
❑ Ptosis
❑ Blindness
❑ Optic atrophy
❑ Retinitis pigmentosis
❑ Hearing loss
❑ Ototoxicity (aminoglycoside-induced)
❑ External ear malformation
❑ Facial dysmorphism
Describe: _____

Neurological/Muscular
❑ Ataxia
❑ Chorea
❑ Dystonia
❑ Hypotonia
❑ Hypertonia
❑ Seizures (type_____)
❑ Spasticity
❑ Exercise intolerance/easy fatigue
❑ Muscle weakness
❑ Stroke/stroke-like episodes
❑ Recurrent headache/migraine

Endocrine
❑ Diabetes mellitus Type I
❑ Diabetes mellitus Type II
❑ Hypothyroidism
❑ Hypoparathyroidism
❑ Pheochromocytoma/ paraganglioma

Behavioral
❑ Autism spectrum disorder
❑ Autistic features
❑ Obsessive-compulsive disorder
❑ Stereotypic behaviors
❑ Other: _____

Brain Malformations/ Abnormal Imaging
❑ Agenesis of the corpus callosum
❑ Holoprosencephaly
❑ Lissencephaly
❑ Cortical dysplasia
❑ Heterotopia
❑ Hydrocephalus
❑ Brain atrophy
❑ Periventricular leukomalacia
❑ Hemimegalencephaly
❑ Abnormalities of basal ganglia
❑ Other: _____

Cardiac/Congenital Heart Malformations
❑ ASD
❑ VSD
❑ Coactation of aorta
❑ Hypoplastic left heart
❑ Tetralogy of Fallot
❑ Cardiomyopathy
❑ Arrhythmia/conduction defect
❑ Other: _____

Hematologic/Immunologic
❑ Recurrent fever
❑ Anemia/neutropenia/ pancytopenia
❑ Immunodeficiency Type_____
❑ Other: _____

Skeletal/Limb abnormalities
❑ Contractures
❑ Club foot
❑ Polydactyly
❑ Syndactyly
❑ Scoliosis
❑ Vertebral anomaly
❑ Other: _____

Gastrointestinal
❑ Gastroschisis/omphalocele
❑ Pyloric stenosis
❑ Tracheoesophageal fistula
❑ Delayed gastric emptying
❑ Eosinophilic esophagitis
❑ Gastrointestinal reflux
❑ Recurrent vomiting
❑ Chronic diarrhea
❑ Constipation
❑ Chronic intestinal pseudo-obstruction
❑ Hirschsprung disease
❑ Hepatic failure
❑ Elevated transaminases

Genitourinary abnormalities
❑ Ambiguous genitalia
❑ Hypospadias
❑ Hydronephrosis
❑ Undescended testis
❑ Kidney malformation
❑ Renal agenesis
❑ Renal tubulopathy
❑ Polycystic kidneys
❑ Multicystic kidneys
❑ Other: _____

Metabolic
❑ Ketosis
❑ Lactic academia/high CSF lactate
❑ Elevated pyruvate
❑ Elevated alanine
❑ Organic aciduria
❑ Low plasma carnitine
❑ Elevated CPK
❑ Hypoglycemia