



Shodair Lab Number

## GENETIC 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  Ashkenazi Jewish  
 Asian  Hutterite  
 Hispanic  American Indian  
 African American  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.*

Signature of ordering provider: \_\_\_\_\_ Date: \_\_\_\_\_

### ADDITIONAL FAMILY SAMPLES (EDTA Whole Blood or Saliva/Buccal Cells)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ Affected:  Yes  No  
 Date of Collection: \_\_\_\_\_ Source: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ Affected:  Yes  No  
 Date of Collection: \_\_\_\_\_ Source: \_\_\_\_\_

### SAMPLE INFORMATION

Whole Blood (≥3mL)  
 Direct Amniotic Fluid  
 Cultured Amniocytes (2-T25)  
 Direct CVS  
 Cultured CVS (2-T25)  
 Saliva/Buccal Cells  
 Extracted DNA (≥10ug) Source: \_\_\_\_\_  
 Fresh/Frozen Tissue Source: \_\_\_\_\_

Date of Collection: \_\_\_\_\_

Reference #: \_\_\_\_\_

Inpatient  Outpatient

### PRIOR AUTHORIZATION IS REQUIRED FOR ALL MOLECULAR TESTING

Prior authorization has been completed & approved, or is not required. Please include a copy of the approval letter with this form.

Prior authorization has **not** been completed. **Please assist with prior authorization.**

You must provide a letter of medical necessity and/or clinical records, ICD-10 codes, copy of front & back of insurance card, and demographic information for our office to assist with prior authorization.

Designated contact for prior authorization 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 BILLING

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: \_\_\_\_\_

### SELF-PAY

Please contact us at 406-444-7532 for service information, cost and a copy of our Self-Pay Patient Agreement.

Name of responsible party: \_\_\_\_\_  
 Relation to patient: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_

Received	Date Received	Tracking #	Sender	Initials



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**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

### REASON FOR TESTING, ICD-10 CODES, AND CLINICAL DIAGNOSIS

*Please include page 3 and/or any additional clinical information (medical records, pictures, family history) to aid in result interpretation.*

Reason for Testing	ICD-10 Codes (required)	Clinical Description	Phenotypic Description	Prenatal Information
<input type="checkbox"/> Diagnostic <input type="checkbox"/> Prenatal <input type="checkbox"/> Carrier Screening <input type="checkbox"/> Family History <input type="checkbox"/> No Family History				LMP: _____ Gestational Age: _____ G: _____ P: _____ Ab: _____ Fetal Sex (if known): _____

### PRENATAL TESTING

Acceptable sample: Direct amniotic fluid, CVS, cultured cells, fresh (unfixed) tissue

We strongly recommend sending a maternal sample (EDTA blood or saliva/buccal) to rule out maternal cell contamination (MCC) on all CVS, direct amniotic fluid, and products of conception samples. MCC studies will be performed as a companion test at no additional charge when a maternal sample is received with the prenatal sample. If a maternal sample is **not** received with the prenatal sample, MCC studies will **not** be performed as a companion test. MCC studies may be ordered separately at a later time, and will be subject to charges. Please contact our office at 406-444-7532 for more information.

### CYTOGENETIC TESTING

Acceptable sample: NaHep blood, direct amniotic fluid, CVS, cultured cells, fresh (unfixed) tissue

- Direct Interphase Aneuploidy FISH (AneuVysion, Chr 13,18,21,X,Y)  
     Reflex to Microarray if Negative. Reflex to Karyotype if Positive.
- Karyotype (Chromosomes)
- Direct Interphase Aneuploidy FISH (AneuVysion, Chr 13,18,21,X,Y)
- Custom FISH: \_\_\_\_\_

### NEXT-GENERATION SEQUENCING (NGS): Gene Panels

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

- Aortopathy (Marfan syndrome, Loeys-Dietz syndrome, etc.)
- Cardiac Arrhythmia including Long QT Syndrome
- Charcot-Marie-Tooth Disease
- Comprehensive Cardiomyopathy
- Ehlers-Danlos Syndromes and Overlapping Hypermobility Syndromes
- Epilepsy
- Hearing Loss
- Neuromuscular Disorders
- Noonan Syndrome
- Osteogenesis Imperfecta
- Short Stature
- Skeletal Dysplasia
- Other NGS Panel/Specify Gene(s)

### CHROMOSOMAL MICROARRAY (CMA)

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

- Chromosomal Microarray

### MOLECULAR GENETIC TESTING

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

- Angelman/Prader-Willi (AS/PWS) Methylation
- Beckwith-Wiedemann Syndrome (BWS)
  - KCNQ10T1 & H19 Methylation
  - Reflex to UPD11 if positive (parent samples required)
- Chromosome 14 Methylation (Temple/Kagami-Ogata S.)
- Duchenne Muscular Dystrophy Deletion/Duplication
- Fragile X Syndrome (FMR-1)
- Hemochromatosis (HFE) Mutations (C282Y / H63D)
- Huntington Disease (HTT) Mutation
- Maternal Cell Contamination (see prenatal testing above)
- Myotonic Dystrophy Type 1 (DM1)
- Parent of Origin Studies for Copy Number Variants
- Russell-Silver Syndrome (RSS)
  - H19 Methylation
  - UPD7 (parent samples required)
- Spinal Muscular Atrophy (SMA)
- Uniparental Disomy Screen (parent samples required)
  - Select Chromosome(s)  2,  6,  7,  8,  9,  11,  13
  - 14,  15,  16,  20,  21
- X-Chromosome Inactivation

### WHOLE EXOME SEQUENCING (WES)

Please visit our website for the Whole Exome Sequencing test request form and consents, or call us at 406-444-7532.

### KNOWN FAMILIAL VARIANT TESTING

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

- Copy Number Analysis
- Sanger Sequence Analysis

**Proband Name & DOB:** \_\_\_\_\_

**Relation to Proband:** \_\_\_\_\_

**Variant Description:** \_\_\_\_\_

If proband studies were not performed at Shodair, please include a copy of the proband report.

If you have questions regarding the appropriate test to order, please contact our office at 406-444-7532.

### Specific Test Instructions

(reflex testing, STAT, etc.)



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**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**CLINICAL INDICATIONS** *(Please check all the apply)*

**Perinatal history**

- 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

**Behavioral**

- Autism spectrum disorder
- Autistic features
- Obsessive-compulsive disorder
- Stereotypic behaviors
- Other psychiatric symptoms

**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: \_\_\_\_\_

**Cardiac/Congenital Heart Malformations**

- ASD
- VSD
- Coarctation of aorta
- Hypoplastic left heart
- Tetralogy of Fallot
- Cardiomyopathy
- Arrhythmia/conduction defect
- Other: \_\_\_\_\_

**Skin/Hair/Nail Abnormalities**

- Abnormal nails \_\_\_\_\_
- Abnormal pigmentation \_\_\_\_\_
- Abnormal connective tissue \_\_\_\_\_
- Blistering
- Ichthyosis
- Skin tumors/malignancies
- 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: \_\_\_\_\_

**Neurological/Muscular**

- Ataxia
- Chorea
- Dystonia
- Hypotonia
- Hypertonia
- Seizures (type: \_\_\_\_\_)
- Spasticity
- Exercise intolerance/easy fatigue
- Muscle weakness
- Stroke/stroke-like episodes
- Recurrent headache/migraine

**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

**Skeletal/Limb Abnormalities**

- Contractures
- Club foot
- Polydactyly
- Syndactyly
- Scoliosis
- Vertebral anomaly
- Other: \_\_\_\_\_

**Genitourinary Abnormalities**

- Ambiguous genitalia
- Hypospadias
- Hydronephrosis
- Undescended testis
- Kidney malformation
- Renal agenesis
- Renal tubulopathy
- Polycystic kidneys
- Multicystic kidneys
- Other: \_\_\_\_\_

**Endocrine**

- Diabetes mellitus
  - Type I
  - Type II
- Hypothyroidism
- Hypoparathyroidism
- Pheochromocytoma/paraganglioma

**Metabolic**

- Ketosis
- Lactic acidemia/high CSF lactate
- Elevated pyruvate
- Elevated alanine
- Organic aciduria
- Low plasma carnitine
- Elevated CPK
- Hypoglycemia

**Hematologic/Immunologic**

- Recurrent fever
- Anemia/neutropenia/pancytopenia
- Immunodeficiency type: \_\_\_\_\_
- Other: \_\_\_\_\_

**Additional Clinical Indications**