Shodair Children's Hospital
Genetics Laboratory
2620 Shodair Dr. Helena, MT 59601
Phone (406) 444-7532 Fax (406) 444-1022

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
☐ Diagnostic ☐ Prenatal ☐ Carrier Screening ☐ Family History ☐ 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:** _____

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)**
  - ☐ **KCNQ1OT1 & 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**

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)**

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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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