BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

AUTISM TESTING REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY)

Address | City | State | Zip | Phone

Accession # | Hospital / Medical Record #

Patient discharged from the hospital/facility: ◯ Yes ◯ No

Biological Sex: ◯ Female ◯ Male ◯ Unknown

Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

ADDITIONAL RECIPIENTS

Name | Email | Fax

Name | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

◯ **SELF PAYMENT**

☐ Pay With Sample ☐ Bill To Patient

◯ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

◯ **INSURANCE**

☐ Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3. Name of Ordering Physician 4. Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone

Primary Member Policy # | Primary Member Group #

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Secondary Insurance Co. Name | Secondary Insurance Co. Phone

Secondary Member Policy # | Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Printed Name | Patient's Signature | Date (MM / DD / YYYY)

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name | Physician's Signature | Date (MM / DD / YYYY)

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ETHNICITY

- ◯ African American
- ◯ Ashkenazi Jewish
- ◯ East Asian (China, Japan, Korea)
- ◯ Finnish
- ◯ French Canadian
- ◯ Hispanic American
- ◯ Mennonite
- ◯ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- ◯ Native American
- ◯ Northern European Caucasian (Scandinavian, UK, Germany)
- ◯ Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- ◯ South Asian (India, Pakistan)
- ◯ Southeast Asian (Vietnam, Cambodia, Thailand)
- ◯ Southern European Caucasian (Spain, Italy, Greece)
- ◯ Other (Specify): _____

SAMPLE

Date of Collection (MM / DD / YYYY) _____ / _____ / _____

SAMPLE TYPE

- ◯ Blood in EDTA Tube (Purple-Top)
- ◯ Blood in Sodium Heparin Tube (Green-Top)
- ◯ DNA, Extracted
- ◯ Liver
- ◯ Plasma (From Heparin)
- ◯ Skeletal Muscle
- ◯ Skin Fibroblast Culture
- ◯ Tissue
- ◯ Urine

NOTE: Extracted DNA/RNA will only be accepted if the isolation of nucleic acids for clinical testing occurs in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.

INDICATION FOR TESTING (REQUIRED)

ICD10 Diagnosis Code(s):

AUTISM TESTS

AUTISM PANELS

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 8100	Male Specific Comprehensive Autism Panel (Includes Biochemistry Multi-Plex)	BE + BH + PH + U
☐ 8110	Female Specific Comprehensive Autism Panel (Includes Biochemistry Multi-Plex)	BE + BH + PH + U
☐ 4000	Biochemistry Multi-Plex	PH + U
☐ 4165	Biochemistry 5-Plex	U
☐ 4175	Biochemistry 3-Plex	PH

AUTISM-RELATED INDIVIDUAL TESTS

BIOCHEMICAL TESTING

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 4100	Amino Acid Analysis	PH
☐ 4300	Acylcarnitine Analysis	PH
☐ 4135	Carnitine Biosynthesis Panel - Urine	U
☐ 4145	Carnitine Biosynthesis Panel - Plasma	PH
☐ 4130	Creatine/Guanidinoacetate Determination	PH
☐ 4260	Creatine/Guanidinoacetate Determination	U
☐ 4140	Homocysteine Determination	PH
☐ 4200	Organic Acid Screen	U
☐ 4220	Purine Panel	U
☐ 4215	Pyrimidine Panel	U

For a complete list of tests offered in each autism panel, please visit BMGL.com. To order Global Metabolomic Assisted Pathway Screen (Global MAPS®), please send sample with Global MAPS® requisition, which can be found at BMGL.com.

MITOCHONDRIAL TESTING

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 2010	Advanced mtDNA Point Mutations & Deletions (BCM-MitomeNGSSM)	BE, SM, T
☐ 2055	Comprehensive mtDNA Analysis (BCMMtomeNGSSM)	BE, T, L, DNA, SM
☐ 2130	mtDNA Depletion/Integrity Panel (BCMMtomeNGSSM)	BE, DNA
☐ 3700	mtDNA Content (qPCR) Analysis - Skeletal Muscle	SM
☐ 3720	mtDNA Content (qPCR) Analysis - Liver	L
☐ 3200	Mitochondrial Respiratory Chain Enzyme Analysis (ETC) - Skeletal Muscle	SM
☐ 3210	Mitochondrial Respiratory Chain Enzyme Analysis (ETC) - Skin Fibroblast Culture	SFC
☐ 2000	MitoMet®Plus aCGH	BE
☐ 2086	Nuclear Panel by Massively Parallel Sequencing (BCM-MitomeNGSSM)	BE, SFC, SM, DNA
☐ 2085	Dual Genome Panel by Massively Parallel Sequencing (BCM-MitomeNGSSM)	BE, SFC, SM, DNA

* Refer to Sample Specifications Table (page 3)

Testing options continued on next page

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AUTISM TESTS - CONTINUED

AUTISM-RELATED INDIVIDUAL TESTS

MITOCHONDRIAL TESTING

TEST CODE	TEST NAME	SAMPLE TYPE *	SPECIFY GENE OF INTEREST
☐ 2001	Oligonucleotide Targeted Array Analysis (Single Target Gene)	BE	
☐ 2003	Oligonucleotide Targeted Array Analysis (Up to 5 Target Genes)	BE	

CYTOGENETIC TESTING

TEST CODE	TEST NAME	SAMPLE TYPE *	SPECIFY GENE OF INTEREST
☐ 8665	CMA - HR + SNP Screen (Comprehensive)	BE + BH	
☐ 8600	Chromosome Analysis	BH	

DNA TESTING

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 6006	Angelman Syndrome Methylation Analysis	BE, DNA
☐ 6007	Angelman Syndrome (*UBE3A* Sequence Analysis)	BE, DNA
☐ 6067	ARX-Related Disorders Sequence Analysis	BE, DNA
☐ 6126	CDKL5-Related Disorders Sequence Analysis	BE, DNA
☐ 6165	CHARGE Syndrome (*CHD7*) Sequence Analysis	BE, DNA
☐ 6573	*FMR1* CGG Repeat Expansion Analysis	BE, DNA
☐ 6240	Lesch-Nyhan Syndrome (*HPRT*) Sequence Analysis	BE, DNA
☐ 6068	*MECP2* Sequence Analysis	BE, DNA

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 6069	MECP2 Deletion/Duplication Analysis	BE, DNA
☐ 6065	Noonan Syndrome (*PTPN11*) Sequence Analysis	BE, DNA
☐ 6475	Noonan Syndrome (*RAF1*) Sequence Analysis	BE, DNA
☐ 6460	Noonan Syndrome (*SOS1*) Sequence Analysis	BE, DNA
☐ 6127	*PLP1* Sequence Analysis	BE, DNA
☐ 6505	*PTEN* Sequence Analysis	BE, DNA
☐ 6121	*RECQL4* Sequence Analysis	BE, DNA
☐ 2510	*TMLHE* Sequence Analysis	BE, DNA

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT (2 YRS - ADULT)	RECOMMENDED AMOUNT (NEWBORN - 2YRS)	SHIPPING INSTRUCTIONS	SPECIAL NOTES
BE	Blood in EDTA tube (purple-top)	3 - 5 cc	2 -3 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
BH	Blood in Sodium Heparin tube (green-top)	3 - 5 cc	1 - 2 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
DNA	DNA, Extracted	10 - 15 ug	10 - 15 ug	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Minimal concentration of 50ng/uL; A260/A280 of ~1.7
L	Liver	25 - 50 mg	25 - 50 mg	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Liver should be flash frozen in liquid nitrogen at collection with no media added and stored at -80°C.
PH	Plasma (From Heparin)	2 cc	2 cc	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Draw blood in Heparin (green-top) tube(s) and separate them as soon as possible. Store the specimen frozen at -20°C. Specimen may be stored frozen for up to 7 days.
SFC	Skin Fibroblast Culture	Two T-25 flasks	Two T-25 flasks	Ship at ambient temperature in an insulated container by overnight courier.	Send two T-25 flasks at approximately 60-80% confluence.
SM	Skeletal Muscle	150 mg	150 mg	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Skeletal Muscle should be flash frozen in liquid nitrogen at collection with no media added, and stored at -80°C. Surgical pathology report required. If a pathology report is not available at this time, please send a clinical summary and the results of any pertinent ancillary testing.
T	Tissue	50 mg	50 mg	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Tissue should be flash frozen in liquid nitrogen at collection with no media added, and stored at -80°C.
U	Urine	3 - 5 cc	2 - 4 cc	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Collect random urine. Do not add preservatives. Store the specimen frozen at -20°C.