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

BIOCHEMICAL 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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SAMPLE

SAMPLE TYPE

- ◯ Blood in ACD (Yellow-top)
- ◯ Blood in Sodium Heparin (Green-top)
- ◯ Blood in EDTA (Purple-top)
- ◯ Cerebrospinal Fluid
- ◯ Cultured Skin Fibroblast
- ◯ Plasma from Sodium Heparin
- ◯ Serum (including marble-top, red-top, etc.)
- ◯ Skeletal Muscle
- ◯ Urine

DATE OF COLLECTION (MM/DD/YYYY)

___ / ___ / ___

INDICATION FOR TESTING (REQUIRED)

ICD10 Diagnosis Code(s):

☐ Clinical management of known diagnosis - Please specify:

☐ Clinical History - Please describe:

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BIOCHEMICAL TESTS

Note: To order Global MAPS® (Metabolomic Assisted Pathway Screen), please visit baylorgenetics.com/reqs

BIOCHEMICAL PANELS

	TEST CODE	TEST NAME	SAMPLE TYPE
☐	4000	Biochemistry Multi-Plex	PH + U
☐	4165	Biochemistry 4-Plex	U
☐	4175	Biochemistry 3-Plex	PH
☐	4015	Creatine Deficiency Syndromes Panel	PH + U
☐	4400	Neonatal and Infantile Seizures Panel	PH + CSF + SE + U
☐	4001	Severe Combined Immunodeficiency (SCID) Newborn Screening Follow-Up Panel	BE + BH + BA + U

ANALYTE ANALYSIS

	TEST CODE	TEST NAME	SAMPLE TYPE
☐	4300	Acylcarnitine Analysis	PH
☐	4100	Amino Acid Analysis	PH
☐	4160	Amino Acid Analysis	CSF
☐	4240	Amino Acid Analysis	U
☐	4145	Carnitine Biosynthesis Panel	PH
☐	4310	Carnitine Determination	PH
☐	4130	Creatine/Guanidinoacetate Determination	PH
☐	4260	Creatine/Guanidinoacetate Determination	U
☐	4627	Cystine Determination	WBC
☐	3210	ETC	SFC
☐	3200	ETC	SM
☐	4140	Homocysteine Determination	PH
☐	4150	Methylmalonic Acid	PH
☐	4200	Organic Acid Screen	U
☐	4110	Phenylalanine Determination	PH
☐	4650	Phenylbutyrate Metabolite Analysis	PH
☐	4651	Phenylbutyrate Metabolite Analysis	U
☐	4220	Purine Panel	U
☐	4811	Pyridoxine-Dependent Seizures Panel	PH
☐	4250	Succinylacetone Determination	U
☐	4225	Sulfocysteine Determination	U
☐	4330	Thymidine Determination	PH

ENZYME ANALYSIS

	TEST CODE	TEST NAME	SAMPLE TYPE
☐	4536	Argininemia / Arginase Deficiency	RBC
☐	4555	Biotidinase Deficiency	SE
☐	4544	Citrullinemia Type I/Argininosuccinate Synthetase 1 Deficiency	SFC
☐	4504	Lysosomal Acid Lipase Analysis/Wolman Disease/ Cholesteryl Ester Storage Disease	WBC
☐	4569	Tay-Sachs Disease & Sandhoff Disease/ Hexosaminidase A and B	SE
☐	4617	Tay-Sachs Disease Carrier Testing Hexosaminidase A	SE
☐	4620	Tay-Sachs Disease Carrier Testing Hexosaminidase A	WBC

SAMPLE TYPE KEY:

BA Blood in ACD tube
BH Blood in Sodium Heparin
BE Blood in EDTA tube
CSF Cerebrospinal Fluid
PH Plasma (From Heparin)
RBC Red Blood Cells
SE Serum
SFC Cultured Skin Fibroblast
SM Skeletal Muscle
U Urine
WBC White Blood Cells

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SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT		SHIPPING INSTRUCTIONS	SPECIAL NOTES
		(2 YRS - ADULT)	(NEWBORN - 2 YRS)		
BA	Blood in ACD tube (yellow-top)	3 - 5 cc	3 - 5 cc	Ship at room temperature in an insulated container by overnight courier to arrive within 36 hours of collection. 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.	
CSF	Cerebrospinal Fluid	1 - 2 cc	1 - 2 cc	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Store the specimen frozen at -20°C. Specimen may be stored frozen for up to 7 days.
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.
RBC	Red Blood Cell	3 - 5 cc	3 - 5 cc	Ship at room temperature in an insulated container by overnight courier to arrive within 36 hours of collection. Do not heat or freeze	Draw blood in an ACD (yellow-top) tube(s).
SE	Serum	1 - 2 cc	1 - 2 cc	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Draw blood in a no-additive (red-top) or serum gel (red/gray-top) tube(s) and separate as soon as possible. Store the specimen at -20°C.
SFC	Skin Fibroblast Culture	Two T-25 flasks	Two T-25 flasks	Ship at ambient temperature in an insulated container by overnight courier. Do not heat or freeze.	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.
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.
WBC	White Blood Cell	7 - 10 cc	3 - 5 cc	Ship at room temperature in an insulated container by overnight courier to arrive within 36 hours of collection. Do not heat or freeze	Draw blood in an ACD (yellow-top) tube(s).