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**

# CUSTOM FAMILY SEQUENCING 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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# CUSTOM FAMILY SEQUENCING REQUISITION

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

## 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 ◯ Buccal Swab ◯ Saliva ◯ DNA (Specify Source): _____ ◯ Other (Specify): _____

**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) _____

## CUSTOM FAMILY SEQUENCING INFORMATION

Test Codes 1580-1589 are to be used when requesting sequencing of a known familial variant(s) for which the Baylor Genetics does not provide a separate test code. These should only be used when the Baylor Genetics has already identified the sequence change in the proband/original patient. If proband testing was performed at another lab, call to discuss prior to sending sample. A positive control may be required in some cases. If testing of proband is needed, see separate requisition "Proband Custom Sequencing Analysis," which can be found at www.bmgl.com.

Name of First Patient Studied | Relationship to Patient Studied | Baylor Genetics Lab # | Family #

This Family Member is Currently:

◯ **ASYMPTOMATIC**

◯ **SYMPTOMATIC** If SYMPTOMATIC, please provide details. Please attach additional pages, if needed. _____

*Include a pedigree showing familial relationships.*

☐ Copy of Original Results Attached (REQUIRED)

## CUSTOM FAMILY SEQUENCING TESTS

Please select one test code per gene for which targeted sequencing is being ordered:

| TEST CODE | TEST NAME | GENE NAME (REQUIRED) | MUTATION/UNCLASSIFIED VARIANT (REQUIRED) |
|---|---|---|---|
| ☐ 1580 | Custom Family Member Sequence Analysis - Gene 1 | | |
| ☐ 1581 | Custom Family Member Sequence Analysis - Gene 2 | | |
| ☐ 1582 | Custom Family Member Sequence Analysis - Gene 3 | | |
| ☐ 1583 | Custom Family Member Sequence Analysis - Gene 4 | | |
| ☐ 1584 | Custom Family Member Sequence Analysis - Gene 5 | | |
| ☐ 1585 | Custom Family Member Sequence Analysis - Gene 6 | | |
| ☐ 1586 | Custom Family Member Sequence Analysis - Gene 7 | | |
| ☐ 1587 | Custom Family Member Sequence Analysis - Gene 8 | | |
| ☐ 1588 | Custom Family Member Sequence Analysis - Gene 9 | | |
| ☐ 1589 | Custom Family Member Sequence Analysis - Gene 10 | | |