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 PROBAND 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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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 PROBAND SEQUENCING INFORMATION

This requisition is intended for the request of confirmation of TARGETED variant(s) testing:

- Confirmation of test results that has not been previously completed in a CLIA/CAP laboratory (such as research lab results)

This requisition should only be used for confirmation of genes which Baylor Genetics does not provide a separate specific test code.

REQUIRED: Lab report identifying original mutation must be included with this requisition. Testing will not begin without documentation from the laboratory that identified the change. The lab report should include the mutation names at nucleotide level and if applicable, amino acid level and/or reference sequence number including version number (Ex: NM_000314.4). NOTE: We are unable to accept samples from a research facility.

If TARGETED testing on FAMILY member of the proband is desired, either after or in conjunction with the proband's testing, please complete the "Family Member Custom Sequencing Requisition" for each family member available at baylorgenetics.com/requisitions/ (See Test Code 1580).

CUSTOM FAMILY SEQUENCING TESTS

FOR AUTOSOMAL DOMINANT, HOMOZYGOUS OR X-LINKED TARGETED GENE TESTING

Use the below test codes (1560-1565 and 1569) for requests when confirmation of only ONE sequence change is being requested for that gene (i.e. autosomal dominant inheritance). Complete one test code request for EACH gene.

TEST CODE	TEST NAME	GENE NAME (REQUIRED)	MUTATION/UNCLASSIFIED VARIANT (REQUIRED)
☐ 1560	Custom Proband Sequence Analysis - Gene 1		
☐ 1561	Custom Proband Sequence Analysis - Gene 2		
☐ 1562	Custom Proband Sequence Analysis - Gene 3		
☐ 1563	Custom Proband Sequence Analysis - Gene 4		
☐ 1564	Custom Proband Sequence Analysis - Gene 5		
☐ 1565	Custom Proband Sequence Analysis - Gene 6		
☐ 1569	Custom Proband Sequence Analysis - Gene 7		

SEE NEXT PAGE FOR RECESSIVE TESTING OPTIONS

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

CUSTOM FAMILY SEQUENCING TESTS

FOR AUTOSOMAL DOMINANT, HOMOZYGOUS OR X-LINKED TARGETED GENE TESTING

Use the below test codes (1570-1579) for requests when confirmation of TWO sequence changes are being requested for that gene (i.e. autosomal recessive inheritance). Complete one test code for EACH gene that TWO sequence changes are being confirmed.

TEST CODE	TEST NAME	GENE NAME (REQUIRED)	MUTATION/UNCLASSIFIED VARIANT (REQUIRED)
☐ 1570	Custom Proband Sequence Analysis - Gene 1		
☐ 1571	Custom Proband Sequence Analysis - Gene 2		
☐ 1572	Custom Proband Sequence Analysis - Gene 3		
☐ 1573	Custom Proband Sequence Analysis - Gene 4		
☐ 1574	Custom Proband Sequence Analysis - Gene 5		
☐ 1575	Custom Proband Sequence Analysis - Gene 6		
☐ 1576	Custom Proband Sequence Analysis - Gene 7		
☐ 1577	Custom Proband Sequence Analysis - Gene 8		
☐ 1578	Custom Proband Sequence Analysis - Gene 9		
☐ 1579	Custom Proband Sequence Analysis - Gene 10		