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

GLOBAL MAPS® 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)

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

GLOBAL MAPS® REQUISITION

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

INDICATION FOR TESTING (REQUIRED)

ICD10 Diagnosis Code(s):

Please provide the following clinical information regarding the patient to be tested. This information is needed to facilitate interpretation of metabolic profiling results. If the laboratory requires additional information, please indicate the healthcare provider to be contacted:

Physician Name | Physician Phone/Pager #

For most accurate results, patient should not be on TPN, special diet, dietary supplements, or drug therapies. Please list all medications and/or supplements the patient has been prescribed and is currently taking:

INDICATION CHECKLIST

INDICATION	YES*	NO	UNKNOWN
Abnormal Movements	☐	☐	☐
Ataxia	☐	☐	☐
Autism/Autistic Spectrum	☐	☐	☐
Delayed Motor Milestones	☐	☐	☐
Delayed Speech	☐	☐	☐
Developmental Regression	☐	☐	☐
Dietary Avoidances	☐	☐	☐
Dysmorphic Features	☐	☐	☐
Eye Problems	☐	☐	☐
Failure to Thrive	☐	☐	☐
Family History of Similar Disorder	☐	☐	☐
Genital Anomalies	☐	☐	☐
GI/Liver Problems	☐	☐	☐
Hearing Loss	☐	☐	☐
Heart Problems	☐	☐	☐
Hyperextensibility	☐	☐	☐
Hypertonia/Spasticity	☐	☐	☐
Hypotonia	☐	☐	☐
Intellectual Disability	☐	☐	☐

INDICATION	YES*	NO	UNKNOWN
Intrauterine Growth Restriction	☐	☐	☐
Joint Contractures	☐	☐	☐
Kidney Problems	☐	☐	☐
Lethargy	☐	☐	☐
Leukodystrophy	☐	☐	☐
Macrocephaly	☐	☐	☐
Microcephaly	☐	☐	☐
Obesity/Overgrowth	☐	☐	☐
Organomegaly	☐	☐	☐
Prematurity	☐	☐	☐
Seizure Disorder	☐	☐	☐
Short Stature	☐	☐	☐
Skeletal Abnormalities	☐	☐	☐
Skin Anomalies	☐	☐	☐
Structural Brain Abnormalities	☐	☐	☐
Tall Habitus	☐	☐	☐
Unusual Odor	☐	☐	☐
Vomiting	☐	☐	☐

* If YES, please provide description below:

PREVIOUS TESTING

☐ Metabolic Testing
(e.g.: Newborn screening, amino acid analysis)

☐ Chromosomal Microarray Analysis (CMA)

☐ Genetic Analysis

If checked, please provide additional details about previous testing in the box below:

TESTING LOCATION

☐ Baylor Genetics

Lab # | Family #

☐ Another laboratory (Attach a copy of the test results)

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

GLOBAL MAPS® 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): _____

REQUIRED ITEMS CHECKLIST

- ☐ Indication for Study Checklist
- ☐ Clinical Note / Summary
- ☐ Proband Sample
- ☐ Requisition

REPORTING

Turnaround time is 3 weeks after financial responsibility has been verified to receive the focused report. Once the focused report is received, the expanded report can be ordered (no additional charge). A requisition for ordering the expanded report is available on our website. Please allow 2 weeks for the expanded report. For more details regarding the reporting system, please visit BMGL.com or call 800-411-GENE.

GLOBAL MAPS® TESTS

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

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 4900	Global Metabolomic Assisted Pathway Screen[1]	PE
☐ 4901	Global Metabolomic Assisted Pathway Screen	U
☐ 4902	Global Metabolomic Assisted Pathway Screen	CSF

[1] Was plasma extracted from EDTA? ◯ Yes ◯ No

(REQUIRED When ordering Test Code 4900)

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT (2 YRS - ADULT)	RECOMMENDED AMOUNT (NEWBORN - 2YRS)	SHIPPING INSTRUCTIONS	SPECIAL NOTES
PE	Plasma (from EDTA)	1 - 2 cc	1 - 2 cc	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Draw blood in an EDTA (purple top) tube(s) and separate as soon as possible, freezing immediately. Send 1 -2 cc of plasma. Store the specimen frozen at -20°C. Specimen may be stored frozen up to 7 days.
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.
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 up to 7 days.

ADDITIONAL STUDIES - RESEARCH

After your results are finalized and reported there may be research studies that you may be eligible for and may be of interest to you. Please read the following statement and select the appropriate box. If the "YES"/contact option is chosen, please complete the additional information requested. Please note that if neither box is selected, the lab will default to the "NO" contact option.

INITIAL ◯ **YES** Baylor Genetics may share my contact information with researchers who have an Institutional Review Board (IRB) approved research study for which I may be eligible for participation. There is no obligation to participate if contacted. No information, other than the contact information below, will be provided to the researcher.

Printed Name | Signature | Date (MM / DD / YYYY)

Relationship to Patient | Patient Name

Preferred Method of Contact: ☐ Email ☐ Mail ☐ Phone

Phone # | Alternative Phone # | Email

Address | City | State | Zip

INITIAL ◯ **NO** I DO NOT wish to be contacted regarding participation in research studies.

*Refer to Sample Specifications Table above