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

INHERITED EYE DISORDERS 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): _____

INDICATION FOR TESTING (REQUIRED)

☐ Symptomatic (Summarize below) ☐ Symptomatic with Family History

_____

☐ Asymptomatic

◯ Population Screening ◯ Positive Family History

Disease | Gene | Variant

ICD10 Diagnosis Code(s): _____

SAMPLE

SAMPLE TYPE

- ◯ Blood in EDTA-tube (purple-top)
- ◯ Blood in Heparin-tube (green-top)
- ◯ DNA
- ◯ Other (Specify)
- ◯ Liver
- ◯ Saliva
- ◯ Skeletal Muscle
- ◯ Tissue

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.

Blood should not be sent from patients who have had a bone marrow transplant or recent blood transfusion

Date of Collection (MM/DD/YY)

TESTING OPTIONS

☐ Targeted Sequencing for Known Familial Mutation (If selected, specify test code and gene below and complete section to the right)

Test Code | Gene

☐ Full Gene Sequencing

☐ Deletion/ Duplication Analysis

FOR TARGETED TESTING SELECTION ONLY

Proband Last Name | Proband First Name

Date of Birth (MM/DD/YY) | Relationship of Proband to Patient

Proband testing location (Select one)

☐ Baylor Genetics Lab# Family#

☐ Another laboratory

1. Attach a copy of the Proband test results
2. A positive control sample of the Proband is requested. Please provide, if available.

INHERITED EYE DISORDERS TESTS

CYTOGENETIC TESTS

TEST CODE	TEST NAME	SAMPLE TYPE*	SPECIFY GENE OF INTEREST	SPECIFY REGION OF INTEREST
☐ 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE + BH		
☐ 8655	Chromosomal Microarray Analysis (CMA) - HR	BE + BH		

MITOCHONDRIAL DNA (MTDNA) MUTATION SCREENS

TEST CODE	TEST NAME	SAMPLE TYPE*
☐ 2010	Advanced mtDNA Point Mutations and Deletions by Massively Parallel Sequencing (BCM-MitomeNGSSM)	BE, SM, T
☐ 2055	Comprehensive mtDNA Analysis by Massively Parallel Sequencing (BCM-MitomeNGSSM)	BE, DNA, L SM, T

* Refer to Sample Specifications Table (page 5)

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FISH STUDIES

MASSIVELY PARALLEL SEQUENCING (BCM-MITOMENGSSM) PANELS

TEST CODE	TEST NAME	SAMPLE TYPE*	TEST CODE	TEST NAME	SAMPLE TYPE*
☐ 20100	Albinism Panel (13 genes)	BE, DNA	☐ 5255	Primary Open Angle Glaucoma Panel (MYOC, OPTN)	BE, DNA
☐ 5260	Developmental Glaucoma Panel (8 genes)	BE, DNA	☐ 2140	Progressive External Ophthalmoplegia Panel (10 genes)	BE, DNA
☐ 5250	Familial Exudative Vitreoretinopathy Panel (FZD4, LRP5, NDP, and TSPAN12)	BE, DNA	☐ 2190	Retinitis Pigmentosa + RPGR orf15 by NGS (66 genes)	BE, DNA
☐ 5090	Leber Congential Amaurosis Panel (19 genes)	BE, DNA	☐ 2195	Usher Syndrome Panel (9 genes)	BE, DNA

DNA COPY NUMBER ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE*	SPECIFY GENE OF INTEREST				
☐ 2000	MitoMet®Plus aCGH Analysis	BE					
☐ 2001	Oligonucleotide Targeted Array Analysis (Single Target Gene)	BE					
☐ 2003	Oligonucleotide Targeted Array Analysis (Up to 5 Target Genes)	BE					

SINGLE GENE ANALYSIS

If a test is not found on this form, please obtain the test code from our website (www.BMGL.com) and write in the below space(s).

Test Code | Gene | Test Code | Gene | Test Code | Gene

Test Name | Test Name | Test Name

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE*
☐ 6603	ABCA4 Comprehensive (Seq. & Del/Dup Analysis)	ABCA4-Related Disorders	BE
☐ 2924	BEST1 Comprehensive (Seq. & Del/Dup Analysis)	BEST1-Related Disorders	BE
☐ 2419	CEP290 Comprehensive (Seq. & Del/Dup Analysis) CEP290	CEP290-Related Disorders	BE
☐ 6655	CDH23 Sequence Analysis	CDH23-Related Disorders	BE
☐ 6660	CLRN1 Sequence Analysis	CLRN1-Related Disorders	BE
☐ 7521	COL2A1 Comprehensive (Seq. & Del/Dup Analysis)	COL2A1-Related Disorders	BE
☐ 2389	CDHR1 Comprehensive (Seq. & Del/Dup Analysis)	Cone-Rod Dystrophy 15	BE
☐ 2849	CRB1 Comprehensive (Seq. & Del/Dup Analysis)	CRB1-Related Disorders	BE
☐ 2954	CRX Comprehensive (Seq. & Del/Dup Analysis)	CRX-Related Disorders	BE
☐ 29215	CYP1B1 Sequence Analysis by NGS	CYP1B1-Related Disorders	BE, DNA
☐ 29260	TSPAN12 Sequence Analysis by NGS	Exudative Vitreoretinopathy 5	BE, DNA
☐ 29255	FZD4 Sequence Analysis by NGS	FZD4-Related Disorders	BE, DNA
☐ 2439	GUCY2D Comprehensive (Seq. & Del/Dup Analysis)	GUCY2D-Related Disorders	BE
☐ 5280	OAT Sequence Analysis	Gyrate Atrophy of Choroid and Retina	BE
☐ 2789	IMPDH1 Comprehensive (Seq. & Del/Dup Analysis)	IMPDH1-Related Disorders	BE
☐ 2394	LCA5 Comprehensive (Seq. & Del/Dup Analysis)	LCA5-Related Disorders	BE

* Refer to Sample Specifications Table (page 5)

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SINGLE GENE ANALYSIS CONTINUED

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE*
☐ 5084	CABP4 Comprehensive (Seq. & Del/Dup Analysis)	Leber Congenital Amaurosis	BE
☐ 5069	IQCB1 Comprehensive (Seq. & Del/Dup Analysis)	Leber Congenital Amaurosis	BE
☐ 6039	OCRL Sequence Analysis	Lowe Syndrome	BE
☐ 2839	LRAT Comprehensive (Seq. & Del/Dup Analysis)	LRAT-Related Disorders	BE
☐ 29265	LRP5 Sequence Analysis by NGS	LRP5-Related Disorders	BE, DNA
☐ 2409	MFRP Comprehensive (Seq. & Del/Dup Analysis)	Microphththalmia, Isolated 5 Disorder	BE
☐ 29270	NDP Sequence Analysis by NGS	NDP-Related Disorders	BE, DNA
☐ 6083	X-Linked, GPR143 Comprehensive (Seq. & Del/Dup Analysis)	Oculocutaneous Albinism	BE
☐ 3469	Type 1, OPA1 Comprehensive (Seq. & Del/Dup Analysis)	Optic Atrophy	BE
☐ 3529	Type 3, OPA3 Comprehensive (Seq. & Del/Dup Analysis)	Optic Atrophy	BE
☐ 29250	OPTN Sequence Analysis by NGS	OPTN-Related Disorders	BE, DNA
☐ 29235	PAX6 Sequence Analysis by NGS	PAX6-Related Disorders	BE, DNA
☐ 29240	PITX2 Sequence Analysis by NGS	PITX2-Related Disorders	BE, DNA
☐ 29220	PITX3 Sequence Analysis by NGS	PITX3-Related Disorders	BE, DNA
☐ 2414	ABHD12 Comprehensive (Seq. & Del/Dup Analysis)	Polyneuropathy, Hearing Loss, Ataxia, Retinitis Pigmentosa, and Cataract Disorder	BE
☐ 29245	MYOC Sequence Analysis by NGS	Primary Open Angle Glaucoma 1A	BE, DNA
☐ 2959	RDH12 Comprehensive (Seq. & Del/Dup Analysis)	RDH12-Related Disorders	BE
☐ 2964	C2orf71 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2764	CA4 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2944	CNGB1 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2969	DHDDS Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2974	EYS Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2994	FAM161A Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2769	FSCN2 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2454	IMPG2 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2984	MERTK Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2459	PDE6B Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2399	PROM1 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2799	PRPF31 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2939	PRPH2 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2479	RGR Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2474	RLBP1 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2814	ROM1 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2449	RP2 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2359	RPGR Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2484	SAG Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2894	TOPORS Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE

* Refer to Sample Specifications Table (page 5)

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SINGLE GENE ANALYSIS CONTINUED

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE*
☐ 29540	RS1 Sequence Analysis by NGS	Retinoschisis	BE, DNA
☐ 2934	RPE65 Comprehensive (Seq. & Del/Dup Analysis)	RPE65-Related Disorders	BE, DNA
☐ 2354	RPGRIP1 Comprehensive (Seq. & Del/Dup Analysis)	RPGRIP1-Related Disorders	BE, DNA
☐ 2899	PRKCG Comprehensive (Seq. & Del/Dup Analysis)	Spinocerebellar Ataxia 14 (SCA)	BE, DNA
☐ 6650	USH2A Sequence Analysis	USH2A-Related Disorders	BE, DNA
☐ 2379	Type 1C, USH1C Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
☐ 2374	Type 1F, PCDH15 Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
☐ 2369	Type 2C, GPR98 Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
☐ 2364	Type 2D, DFNB31 Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
☐ 29230	VSX1 Sequence Analysis	VSX1-Related Disorders	BE, DNA

* Refer to Sample Specifications Table below

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT		SHIPPING INSTRUCTIONS	SPECIAL NOTES
		(2 YRS - ADULT)	(NEWBORN - 2 YRS)		
BE	Blood in EDTA tube (purple-top)	10 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	hip at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
DNA	DNA, Extracted	10 - 15 ug	1 - 2 cc	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	10 - 15 mg	2 - 3 cc	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.
SA	Saliva	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Collected with Oragene DNA Self-Collection Kit.
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.