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

AUTISM 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

Genetic 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): _____

SAMPLE

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

SAMPLE TYPE

- ◯ Blood in EDTA Tube (Purple-Top)
- ◯ Blood in Sodium Heparin Tube (Green-Top)
- ◯ DNA, Extracted
- ◯ Liver
- ◯ Plasma (From Heparin)
- ◯ Skeletal Muscle
- ◯ Skin Fibroblast Culture
- ◯ Tissue
- ◯ Urine

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):

AUTISM TESTS

AUTISM PANELS

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 8100	Male Specific Comprehensive Autism Panel *Acylcarnitine Analysis (TC 4300), Amino Acid Analysis (TC 4100), CMA - HR + SNP Screen (TC 8665), Plasma and Urine Creatine/Guanidinoacetate Determination (TC 4130 & 4260), FMR1 CGG Repeat (TC 6573), Organic Acid Screen (TC 4200)*	BE + BH + PH + U
☐ 8110	Female Specific Comprehensive Panel *Acylcarnitine Analysis (TC 4300), Amino Acid Analysis (TC 4100), CMA - HR + SNP Screen (TC 8665), Plasma and Urine Creatine/Guanidinoacetate Determination (TC 4130 & 4260), FMR1 CGG Repeat (TC 6573), MECP2 Sequence Analysis (TC 6068), MECP2 Deletion/Duplication Analysis (TC 6069), Organic Acid Screen (TC 4200)*	BE + BH + PH + U
☐ 4000	Biochemistry 5-Plex *Acylcarnitine Analysis (TC 4300), Amino Acid Analysis (TC 4100), Creatine/Guanidinoacetate Determination (PH) (TC 4130), Plasma and Urine Creatine/Guanidinoacetate Determination (TC 4130 & 4260), Organic Acid Screen (TC 4200)*	PH + U
☐ 4175	Biochemistry 3-Plex *Acylcarnitine Analysis (TC 4300), Amino Acid Analysis (TC 4100), Creatine/Guanidinoacetate Determination (PH) (TC 4130)*	PH

AUTISM-RELATED INDIVIDUAL TESTS

BIOCHEMICAL TESTING

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 4100	Amino Acid Analysis	PH
☐ 4300	Acylcarnitine Analysis	PH
☐ 4135	Carnitine Biosynthesis Panel - Urine	U
☐ 4130	Creatine/Guanidinoacetate Determination	PH
☐ 4260	Creatine/Guanidinoacetate Determination	U
☐ 4200	Organic Acid Screen	U

MITOCHONDRIAL TESTING

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 2010	Advanced mtDNA Point Mutations & Deletions (BCM-MitomeNGSSM)	BE, SM, T
☐ 2055	Comprehensive mtDNA Analysis (BCMMtomeNGSSM)	BE, T, L, DNA, SM
☐ 2130	mtDNA Depletion/Integrity Panel (BCMMtomeNGSSM)	BE, DNA
☐ 3700	mtDNA Content (qPCR) Analysis - Skeletal Muscle	SM
☐ 3720	mtDNA Content (qPCR) Analysis - Liver	L
☐ 3200	Mitochondrial Respiratory Chain Enzyme Analysis (ETC) - Skeletal Muscle	SM
☐ 3210	Mitochondrial Respiratory Chain Enzyme Analysis (ETC) - Skin Fibroblast Culture	SFC
☐ 2000	MitoMet®Plus aCGH	BE
☐ 2086	Nuclear Panel by Massively Parallel Sequencing (BCM-MitomeNGSSM)	BE, SFC, SM, DNA
☐ 2085	Dual Genome Panel by Massively Parallel Sequencing (BCM-MitomeNGSSM)	BE, SFC, SM, DNA

For a complete list of tests offered in each autism panel, please visit BMGL.com. To order Global Metabolomic Assisted Pathway Screen (Global MAPS®), please send sample with Global MAPS® requisition, which can be found at BMGL.com.

* Refer to Sample Specifications Table (page 3)

Testing options continued on next page

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AUTISM TESTING REQUISITION

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

AUTISM TESTS - CONTINUED

AUTISM-RELATED INDIVIDUAL TESTS

MITOCHONDRIAL TESTING

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

CYTOGENETIC TESTING

TEST CODE	TEST NAME	SAMPLE TYPE *	SPECIFY GENE OF INTEREST
☐ 8665	CMA - HR + SNP Screen (Comprehensive)	BE + BH	
☐ 8600	Chromosome Analysis	BH	

DNA TESTING

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 6006	Angelman Syndrome Methylation Analysis	BE, DNA
☐ 6007	Angelman Syndrome (*UBE3A* Sequence Analysis)	BE, DNA
☐ 6067	ARX-Related Disorders Sequence Analysis	BE, DNA
☐ 6126	CDKL5-Related Disorders Sequence Analysis	BE, DNA
☐ 6165	CHARGE Syndrome (*CHD7*) Sequence Analysis	BE, DNA
☐ 6573	*FMR1* CGG Repeat Expansion Analysis	BE, DNA
☐ 6240	Lesch-Nyhan Syndrome (*HPRT*) Sequence Analysis	BE, DNA
☐ 6068	*MECP2* Sequence Analysis	BE, DNA

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 6069	MECP2 Deletion/Duplication Analysis	BE, DNA
☐ 6065	Noonan Syndrome (*PTPN11*) Sequence Analysis	BE, DNA
☐ 6475	Noonan Syndrome (*RAF1*) Sequence Analysis	BE, DNA
☐ 6460	Noonan Syndrome (*SOS1*) Sequence Analysis	BE, DNA
☐ 6127	*PLP1* Sequence Analysis	BE, DNA
☐ 6505	*PTEN* Sequence Analysis	BE, DNA
☐ 6121	*RECQL4* Sequence Analysis	BE, DNA
☐ 2510	*TMLHE* Sequence Analysis	BE, DNA

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT (2 YRS - ADULT)	RECOMMENDED AMOUNT (NEWBORN - 2YRS)	SHIPPING INSTRUCTIONS	SPECIAL NOTES
BE	Blood in EDTA tube (purple-top)	3 - 5 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	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
DNA	DNA, Extracted	10 - 15 ug	10 - 15 ug	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	25 - 50 mg	25 - 50 mg	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.
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.
SFC	Skin Fibroblast Culture	Two T-25 flasks	Two T-25 flasks	Ship at ambient temperature in an insulated container by overnight courier.	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.
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.
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.

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INFORMED CONSENT FOR AUTISM TESTING

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

TEST INFORMATION

This consent form will provide you with information regarding genetic testing, which you should discuss with your healthcare provider or a genetic counselor. To assist you in understanding the reason for this testing, we have provided information about the testing process and potential results below.

The purpose of genetic testing is to determine if a genetic disease may be present or if there is an increased risk for a genetic disease to occur in a patient or their family. DNA is the genetic material that we receive from our parents. Genes are made of DNA and are the instructions for maintaining the health of our body. Each person has a unique set of DNA and most of the differences in our DNA do not impact our health. Genetic testing analyzes DNA to find any abnormal changes (mutations also called variants) that might cause disease, make it more likely to develop disease, and/or increase the chance of having a child affected by disease.

The testing ordered by your healthcare provider can determine if you or your child have a variant associated with a genetic disease. "Your child" can also mean your unborn child, for the purposes of this consent.

Depending on why genetic testing is needed, you might be tested for:

- A known variant that has already been found in your family
- A single gene or variant that causes a specific, suspected disease.
- Multiple genes at the same time. These genes might cause similar diseases or might cause diseases that are unrelated to each other.
- Multiple types of testing that each test for different variants.

RESULTS

There are several types of test results that may be reported including:

- Positive: Positive or "abnormal" results mean there is a change in the DNA found that is related to your/your child's medical issues or that you/your child are at an increased risk of developing a disease in the future. It is possible to test positive for more than one variant. Positive results might include pathogenic variants (variants known to be associated with disease) and likely pathogenic variants (variants that are likely to be associated with disease).
- Negative: Negative or "normal" results mean no relevant variants related to your/your child's medical issues were detected or that you/your child are not expected to be at an increased risk for developing a disease in the future. This might indicate that there are no variants associated with disease in the gene(s) tested. Genetic testing, while highly accurate, might not detect a variant present in the gene(s) tested. This can be due to limitations of the information available about the gene(s) being tested, or limitations of the testing technology.
- Variant of Uncertain Significance: Testing can detect variant(s) in DNA which we do not yet fully understand. These are also referred to as variants of uncertain significance (VUS). Additional testing may be recommended for you or your family if a VUS is identified in a gene that may be associated with your/your child's medical condition.
- Secondary / Incidental Findings: Testing can sometimes detect a variant in a person's DNA unrelated to the reason for testing. If this variant is expected to have medical or reproductive significance, it is called a secondary or incidental finding.

CONSIDERATIONS AND LIMITATIONS

- This consent form cannot be used for whole exome sequencing (WES), whole genome sequencing (WGS), or Huntington's disease testing. These tests have specific consents that are located at https://www.baylorgenetics.com/consent/.
- Results may indicate you have a genetic disease, are at increased risk to develop a genetic disease, and/or be at an increased risk to have a child with a genetic disease. It is important to understand that genetic tests, even if negative, cannot rule out every variant. It is not possible to exclude risks for all genetic diseases for you and your family members.
- Depending on the type of genetic testing performed and the results, additional genetic testing or other testing may be needed to fully understand the likelihood of your developing the disease or the severity of the disease. This additional testing might be needed for you/your child or other members of your family.
- It is recommended that you discuss genetic testing with your healthcare provider or genetic counselor before signing this consent and again after results are made available.
- It may not always be possible to complete testing. as sometimes the sample does not have enough DNA to perform testing or other reasons. In these cases, another sample may need to be sent to the laboratory to perform testing.

PATIENT CONFIDENTIALITY AND SPECIMEN RETENTION

- If several family members are tested, the correct interpretation of the results depends on the information provided about the relationships amongst family members. In rare cases, genetic testing can reveal that the true biological relationships in a family are not as they were reported. If a difference is identified, it may be necessary to share this information with the healthcare provider who ordered the testing.

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INFORMED CONSENT FOR AUTISM TESTING

Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM / DD / YYYY) ____ / ____ / ____ Genetic Sex _____

PATIENT CONFIDENTIALITY AND SPECIMEN RETENTION (CONT.)

- Genetic testing is highly accurate, however in rare cases, inaccurate results may occur. Reasons for this include, but are not limited to, mislabeled samples, inaccurate reporting of clinical/medical information, or rare technical errors.
- If you sign this consent form, but you no longer wish to have your sample(s) tested, you can contact the healthcare provider who ordered the test to cancel the test. If you wish to cancel testing, the laboratory must be notified of the cancellation request before 5 PM CST the business day after the sample has begun testing. If the laboratory is not notified of your cancellation request until after this time, you will be charged for the full cost of the test.
- Only Baylor Genetics and Baylor Genetics contracted partners will have access to the sample(s) provided to conduct the requested testing. Results will only be released to the following person(s): (i) a licensed healthcare provider, (ii) those authorized in writing, (iii) the patient or their personal representative, and (iv) those allowed access to test results by law. I understand that I have the right to access any test results directly from Baylor Genetics by providing a written request. I also understand that laboratory raw data, while not routinely released as part of the testing process, can be requested by providing a written request or HIPAA Authorization Form.
- In rare cases, persons with genetic diagnoses have experienced problems with insurance coverage and employment. The U.S. Federal Government has enacted several laws that prohibit discrimination based on genetic test results by health insurance companies and employers. In addition, these laws prohibit unauthorized disclosure of this information. For more information, you can visit www.genome.gov/10002077.
- Samples will be retained in the laboratory in accordance with the laboratory retention policy.
- After testing is complete, the de-identified submitted specimen may be used for test development and improvement, internal validation, quality assurance, and training purposes. DNA specimens are not returned to individuals or to referring heath care providers unless specific prior arrangements have been made.
- Samples from residents of New York State will not be included in research studies without your written consent and will not be retained for more than 60 days after receipt of the sample. No tests other than those authorized shall be performed on the biological sample.
- By signing this consent form, I understand and agree that variants identified may also be submitted to public databases, such as ClinVar. Such submission serves to contribute knowledge to the medical community. I understand that limited clinical information is also required for the submission of information to ClinVar's database and further that the contents of this limited clinical information may, although unlikely, include information that may identify me personally.
- It is possible that even if the test identifies the underlying genetic cause for the disease in your family, this information may not help in predicting the progression of disease or change management or treatment of disease.

FINANCIAL AGREEMENT AND GUARANTEE

By signing this consent form, I accept full and complete financial responsibility for all genetic testing ordered by my healthcare provider. For insurance billing, I hereby authorize Baylor Genetics to bill my health insurance plan on my behalf, and further authorize Baylor Genetics to release any information to my insurance carrier which is reasonably required for billing. I additionally designate Baylor Genetics as my designated representative for purposes of appealing any denial of benefits by my insurance carrier. I irrevocably assign associated payment to Baylor Genetics, and direct that payment be made directly to Baylor Genetics. I understand that my out-of-pocket costs may be different than the estimated amount indicated to me by Baylor Genetics as part of a verification of benefits investigation. I agree to be financially responsible for all amounts as indicated on the explanation of benefits issued by my health insurance plan. If my insurance provider sends a payment directly to me for unpaid services performed by Baylor Genetics on my behalf, I agree to endorse the insurance check as appropriate and forward such check to Baylor Genetics within thirty (30) days of receipt thereof, as payment towards Baylor Genetics' claim for services rendered. If I do not have health insurance, I agree to pay for the full cost of the genetic testing that was ordered by my healthcare provider and billed to me by Baylor Genetics.

I understand that a completed Advance Beneficiary Notice (ABN) is required for Medicare patients if the service is deemed not medically necessary.

RECONTACT FOR RESEARCH CONSENT

Baylor Genetics participates in research relating to health, disease prevention, drug development, and other scientific purposes. Baylor Genetics may contact patients or their provider(s) directly as part of this research. I agree to allow Baylor Genetics to contact me or my provider(s) about possible research involving the sample(s) and/or information associated with this testing. I understand that patients generally receive no compensation for this participation in research. For more information on research at Baylor Genetics, please visit baylorgenetics.com.

If I wish to opt out of being recontacted for research purposes by Baylor Genetics, I understand that I may check the box below:

☐ Please do not contact me regarding any research that uses information obtained from this testing.

For any research I may be contacted about, I prefer contact through the following methods (please check all that apply – if no choices are selected, contact will be made via secure email if possible):

☐ Email ☐ Phone ☐ Mail

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			____ / ____ / ____	

PATIENT AUTHORIZATION

By signing this statement of consent, I acknowledge that I have read, understand, and hereby grant my informed consent for genetic testing. I have received appropriate explanations from my healthcare provider about the planned genetic test(s) and possible results. I have been informed by my healthcare provider about the availability and importance of genetic counseling and have been provided with written information identifying a genetic counselor or medical geneticist who can provide such counseling services. All my questions have been answered and I have had the necessary time to make an informed decision about the genetic test(s).

I hereby give permission to Baylor Genetics to conduct genetic testing as recommended by my physician.

Patient's Printed Name	Patient's Signature	Date (MM / DD / YYYY)
		____ / ____ / ____

Patient's Parent / Personal Representative* Name	Patient's Parent / Personal Representative Signature	Date (MM / DD / YYYY)
		____ / ____ / ____

Relationship of Personal Representative to the Patient	Ordering Provider's Signature	Date (MM / DD / YYYY)
		____ / ____ / ____

*If you are signing as a person with legal authority to act on behalf of the patient, you may be required to provide evidence of your authority.