

MITOCHONDRIAL 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
Accession #	Hospital / Medical Record #	Patient discharged from the hospital/facility: <input type="radio"/> Yes <input type="radio"/> No	
		Genetic Sex: <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> 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
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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)	Name of Insured	Insured Date of Birth (MM / DD / YYYY)
Patient's Relationship to Insured	Phone of Insured	Patient's Relationship to Insured	Phone of Insured
Address of Insured		Address of Insured	
City	State	City	State
	Zip		Zip
Primary Insurance Co. Name	Primary Insurance Co. Phone	Secondary Insurance Co. Name	Secondary Insurance Co. Phone
Primary Member Policy #	Primary Member Group #	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)
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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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MITOCHONDRIAL TESTING REQUISITION

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

ETHNICITY

- | | | |
|--|---|---|
| <input type="radio"/> African American | <input type="radio"/> Hispanic American | <input type="radio"/> Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia) |
| <input type="radio"/> Ashkenazi Jewish | <input type="radio"/> Mennonite | <input type="radio"/> South Asian (India, Pakistan) |
| <input type="radio"/> East Asian (China, Japan, Korea) | <input type="radio"/> Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey) | <input type="radio"/> Southeast Asian (Vietnam, Cambodia, Thailand) |
| <input type="radio"/> Finnish | <input type="radio"/> Native American | <input type="radio"/> Southern European Caucasian (Spain, Italy, Greece) |
| <input type="radio"/> French Canadian | <input type="radio"/> Northern European Caucasian (Scandinavian, UK, Germany) | <input type="radio"/> Other (Specify): _____ |

SAMPLE
SAMPLE TYPE

- | SAMPLE TYPE | DATE OF COLLECTION (MM/DD/YYYY) |
|--|---------------------------------|
| <input type="radio"/> Blood in EDTA (Purple-top) | ____ / ____ / ____ |
| <input type="radio"/> Cord Blood | ____ / ____ / ____ |
| <input type="radio"/> DNA, Extracted from: | ____ / ____ / ____ |
| <input type="radio"/> Liver | ____ / ____ / ____ |
| <input type="radio"/> Saliva | ____ / ____ / ____ |
| <input type="radio"/> Skin Fibroblast Culture | ____ / ____ / ____ |
| <input type="radio"/> Skeletal Muscle | ____ / ____ / ____ |
| <input type="radio"/> Skin Biopsy* | ____ / ____ / ____ |
| <input type="radio"/> 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.

TESTING OPTIONS

-
- Targeted Sequencing for Known Familial Mutation
-
- (If selected, specify test code and gene and complete section below)

Test Code _____ Gene _____

Proband Last Name _____ Proband First Name _____

Relationship to Proband _____ Date of Birth (MM/DD/YYYY) _____

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.

-
- Full Gene Sequencing
-
-
- Deletion/ Duplication Analysis

INDICATION FOR TESTING (REQUIRED)

-
- Symptomatic with Positive Family History

-
- Symptomatic (Summarize below):

-
- Asymptomatic

-
- Population Screening
-
- Positive Family History

Disease _____ Gene _____ Variant _____

ICD10 Diagnosis Code(s):

MITOCHONDRIAL TESTS
MITOCHONDRIAL PANELS

TEST CODE	TEST NAME	SAMPLE TYPE *
<input type="checkbox"/> 2085	Dual Genome Panel by Massively Parallel Sequencing (BCM-MitomeNGS SM)	BE, DNA, T, SFC
<input type="checkbox"/> 20600	Dual Genome Leigh Disease Panel by Massively Parallel Sequencing (BCM-MitomeNGS SM)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/> 2055	Comprehensive mtDNA by Massively Parallel Sequencing (BCM-MitomeNGS SM)	BE, DNA, T, SFC

MASSIVELY PARALLEL SEQUENCING (BCM-MITOMENGSSM) PANELS

TEST CODE	TEST NAME	SAMPLE TYPE *
<input type="checkbox"/> 20100	Albinism Panel (13 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/> 20400	Bardet-Biedl Syndrome Panel (18 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/> 2105	Cholestasis Panel (7 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/> 2120	Cobalamin Metabolism Panel + Severe <i>MTHFR</i> Deficiency (20 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/> 2625	<i>COL1A1</i> and <i>COL1A2</i> Panel	BE, DNA, SFC, BUC, SA

* This sample type incurs an additional fee and typically adds 14 days to the turnaround time, depending on sample quality.
 † Baylor Genetics will store this sample for up to 14 days after the report is issued, allowing for follow-up testing if needed.

MITOCHONDRIAL TESTING REQUISITION

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MITOCHONDRIAL TESTS
MASSIVELY PARALLEL SEQUENCING (BCM-MITOMENGSSM) PANELS

TEST CODE	TEST NAME	SAMPLE TYPE *
<input type="checkbox"/>	5095 Congenital Disorders of Glycosylation Panel (36 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2100 CoQ10 Deficiency Panel (<i>PDSS1, PDSS2, COQ2, COQ9, and ADCK3(COQ8/CABC1)</i>)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	5260 Developmental Glaucoma Panel (8 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	5250 Familial Exudative Vitreoretinopathy Panel (<i>FZD4, LRP5, NDP, and TSPAN12</i>)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2095 Fatty Acid Oxidation Panel (20 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2125 Glycogen Storage Disease (GSD) Panel (23 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2126 Glycogen Storage Disease (GSD) Muscle Panel (13 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2127 Glycogen Storage Disease (GSD) Liver Panel (13 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2200 High Bone Mass Panel (14 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	21700 Hyperinsulinism Panel (8 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	21000 Hypoglycemia Panel (85 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	5090 Leber Congenital Amaurosis Panel (19 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	20601 Leigh Disease Panel (82 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2090 Low Bone Mass Panel (23 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	32870 Maple Syrup Urine Disease (MSUD) Panel (<i>BCKHDA, BCKHDB, DBT and DLD</i>)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	21900 Maturity-Onset Diabetes of the Young (MODY) Panel (25 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2130 mtDNA Depletion/Integrity Panel (19 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2155 Mitochondrial Respiratory Chain Complex I Deficiency Panel (21 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2160 Mitochondrial Respiratory Chain Complex II Deficiency Panel (<i>SDHA, SDHB, SDHC, SDHD, and SDHAF1</i>)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2165 Mitochondrial Respiratory Chain Complex III Deficiency Panel (<i>BCS1L, TTC19, UQCRB, and UQCRCQ</i>)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2170 Mitochondrial Respiratory Chain Complex IV Deficiency Panel (10 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2175 Mitochondrial Respiratory Chain Complex V Deficiency Panel (<i>ATPAF2, ATP5E, and TMEM70</i>)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2086 Nuclear Panel (163 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2180 Mitochondrial Respiratory Chain Complex I-V Panel (50 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2300 Myopathy/Rhabdomyolysis Panel (25 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	20200 Nephronophthisis Panel (<i>NPHP1, INVS, NPHP3, NPHP4</i>)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	24001 Noonan Spectrum Disorders Panel (26 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2185 PDH & Mitochondrial RC Complex V Panel (9 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	22100 Peroxisomal Disorders Panel (22 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	5255 Primary Open Angle Glaucoma Panel (MYOC, OPTN)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	5274 Proximal Urea Cycle Disorders Comprehensive (Seq. & Del/Dup) (<i>CPS1, NAGS, OTC</i>)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2140 Progressive External Ophthalmoplegia Panel (10 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2190 Retinitis Pigmentosa + RPGR orf15 by NGS (66 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2110 Urea Cycle Disorders and Hyperammonemia (8 genes)	BE, DNA, SFC, BUC, SA
<input type="checkbox"/>	2195 Usher Syndrome Panel (9 genes)	BE, DNA, SFC, BUC, SA

DNA COPY NUMBER ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE *	SPECIFY GENE OF INTEREST
<input type="checkbox"/>	3700 mtDNA Content (qPCR) Analysis - Skeletal Muscle**	SM	
<input type="checkbox"/>	3720 mtDNA Content (qPCR) Analysis - Liver**	L	
<input type="checkbox"/>	2000 MitoMet [®] Plus aCGH Analysis	BE	
<input type="checkbox"/>	2001 Oligonucleotide Targeted Array Analysis (Single Target Gene)	BE	<input type="text"/>
<input type="checkbox"/>	2003 Oligonucleotide Targeted Array Analysis (Up to 5 Target Genes)	BE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

** Skin biopsy sample type not available for this test

MITOCHONDRIAL TESTING REQUISITION

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

MITOCHONDRIAL TESTS
MITOCHONDRIAL DNA (mtDNA) RESPIRATORY CHAIN ENZYME TESTS

TEST CODE	TEST NAME	SAMPLE TYPE *
<input type="checkbox"/> 3200	Mitochondrial Respiratory Chain Enzyme Analysis (ETC) - Skeletal Muscle**	SM
<input type="checkbox"/> 3210	Mitochondrial Respiratory Chain Enzyme Analysis (ETC) - Skin Fibroblasts	SFC

MITOCHONDRIAL DNA (mtDNA) MUTATION SCREENS
MITOCHONDRIAL DNA (mtDNA) MUTATION SCREENS

TEST CODE	TEST NAME	SAMPLE TYPE *	TEST CODE	TEST NAME	SAMPLE TYPE *
<input type="checkbox"/> 2010	Advanced mtDNA Point Mutations and Deletions by Massively Parallel Sequencing (BCM-MitomeNGS SM)	BE, DNA, SFC, T	<input type="checkbox"/> 3030	mtDNA Nonsyndromic Hearing Loss and Deafness Mutation Panel	BE, SA, SM, T

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 *
<input type="checkbox"/> 3904	ACAD9 Comprehensive (Seq & Del/Dup Analysis)	ACAD9 Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2219	ATP5A1 Comprehensive (Seq & Del/Dup Analysis)	ATP5A1-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 3614	TAZ Comprehensive (Seq & Del/Dup Analysis)	Barth Syndrome (TAZ-Related Disorders)	BE, DNA, BUC, SA
<input type="checkbox"/> 3179	C10orf2 (TWINKLE) Comprehensive (Seq & Del/Dup Analysis)	C10orf2 (TWINKLE)-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 3854	CABC1(ADCK3) Comprehensive (Seq & Del/Dup Analysis)	Coenzyme Q10 Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3419	COQ2 Comprehensive (Seq & Del/Dup Analysis)	Coenzyme Q10 Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3414	PDSS2 Comprehensive (Seq & Del/Dup Analysis)	Coenzyme Q10 Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2264	GFM1 Comprehensive (Seq & Del/Dup Analysis)	Combined Oxidative Phosphorylation Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3649	TSFM Comprehensive (Seq & Del/Dup Analysis)	Combined Oxidative Phosphorylation Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2289	MRPS22 Comprehensive (Seq & Del/Dup Analysis)	Combined Oxidative Phosphorylation Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2224	C12orf65 Comprehensive (Seq & Del/Dup Analysis)	Combined Oxidative Phosphorylation Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2324	AARS2 Comprehensive (Seq & Del/Dup Analysis)	Combined Oxidative Phosphorylation Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2664	FOXRED1 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3489	NDUFA1 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2684	NDUFA11 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3944	NDUFAF1 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3539	NDUFAF2 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2694	NDUFAF3 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2704	NDUFS1 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3574	NDUFS3 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA

** Skin biopsy sample type not available for this test

MITOCHONDRIAL TESTING REQUISITION

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

MITOCHONDRIAL TESTS
SINGLE GENE ANALYSIS

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE *
<input type="checkbox"/> 3564	NDUFS4 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3569	NDUFS6 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3849	NDUFS8 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3594	NDUFV1 Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2714	NUBPL Comprehensive (Seq & Del/Dup Analysis)	Complex I Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3180	SDHA Sequence Analysis	Complex II Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3185	SDHB Sequence Analysis	Complex II Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3190	SDHC Sequence Analysis	Complex II Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3195	SDHD Sequence Analysis	Complex II Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3679	SDHAF1 Comprehensive (Seq & Del/Dup Analysis)	Complex II Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3114	BCS1L Comprehensive (Seq & Del/Dup Analysis)	Complex III Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2719	TTC19 Comprehensive (Seq & Del/Dup Analysis)	Complex III Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2734	COX4I1 Comprehensive (Seq & Del/Dup Analysis)	Complex IV Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3104	COX10 Comprehensive (Seq & Del/Dup Analysis)	Complex IV Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3549	COX15 Comprehensive (Seq & Del/Dup Analysis)	Complex IV Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3099	SCO1 Comprehensive (Seq & Del/Dup Analysis)	Complex IV Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3094	SCO2 Comprehensive (Seq & Del/Dup Analysis)	Complex IV Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3089	SURF1 Comprehensive (Seq & Del/Dup Analysis)	Complex IV Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 2749	TACO1 Comprehensive (Seq & Del/Dup Analysis)	Complex IV Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3294	ATP5E Comprehensive (Seq & Del/Dup Analysis)	Complex V Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3739	TMEM70 Comprehensive (Seq & Del/Dup Analysis)	Complex V Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3344	TIMM8A Comprehensive (Seq & Del/Dup Analysis)	Deafness-Dystonia-Optic Neuropathy	BE, DNA, BUC, SA
<input type="checkbox"/> 3079	DGUOK Comprehensive (Seq & Del/Dup Analysis)	DGUOK-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 3749	ETHE1 Comprehensive (Seq & Del/Dup Analysis)	Ethylmalonic Encephalopathy	BE, DNA, BUC, SA
<input type="checkbox"/> 2249	FARS2 Comprehensive (Seq & Del/Dup Analysis)	FARS2-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 3559	FASTKD2 Comprehensive (Seq & Del/Dup Analysis)	FASTKD2-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 2314	HARS2 Comprehensive (Seq & Del/Dup Analysis)	HARS2-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 2329	KARS Comprehensive (Seq & Del/Dup Analysis)	Intermediate Charcot-Marie-Tooth Neuropathy, KARS-Related	BE, DNA, BUC, SA
<input type="checkbox"/> 2269	ACAT1 Comprehensive (Seq & Del/Dup Analysis)	Ketothiolase Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3464	DLD Comprehensive (Seq & Del/Dup Analysis)	Maple Syrup Urine Disease Type 3	BE, DNA, BUC, SA
<input type="checkbox"/> 2229	MARS2 Comprehensive (Seq & Del/Dup Analysis)	MARS2 Related Disorders	BE, DNA, BUC, SA

* Refer to Sample Specifications Table (Page 8)

Test list continued on next page

MITOCHONDRIAL TESTING REQUISITION

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

MITOCHONDRIAL TESTS
INDIVIDUAL MITOCHONDRIAL TESTS (LISTED BY DISORDER)

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE *
<input type="checkbox"/> 3964	SUCLG2 Comprehensive (Seq & Del/Dup Analysis)	mtDNA Depletion Syndrome, SUCLG2-Related	BE, DNA, BUC, SA
<input type="checkbox"/> 3074	TK2 Comprehensive (Seq & Del/Dup Analysis)	mtDNA Depletion Syndrome, Myopathic Form (TK2-Related Disorders)	BE, DNA, BUC, SA
<input type="checkbox"/> 3064	TYMP Comprehensive (Seq & Del/Dup Analysis)	MNGIE/MNGIE like Syndrome	BE, DNA, BUC, SA
<input type="checkbox"/> 3324	MPV17 Comprehensive (Seq & Del/Dup Analysis)	MPV17-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 2294	MRPL44 Comprehensive (Seq & Del/Dup Analysis)	MRPL44-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 2235	MTFMT Sequence Analysis	MTFMT-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 3659	ISCU Comprehensive (Seq & Del/Dup Analysis)	Myopathy with Deficiency of ISCU	BE, DNA, BUC, SA
<input type="checkbox"/> 3654	PUS1 Comprehensive (Seq & Del/Dup Analysis)	Myopathy, Mitochondrial, and Sideroblastic Anemia	BE, DNA, BUC, SA
<input type="checkbox"/> 3959	YARS2 Comprehensive (Seq & Del/Dup Analysis)	Myopathy, Mitochondrial, and Sideroblastic Anemia	BE, DNA, BUC, SA
<input type="checkbox"/> 2309	NARS2 Comprehensive (Seq & Del/Dup Analysis)	NARS2-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 3529	OPA3 Comprehensive (Seq & Del/Dup Analysis)	Optic Atrophy Type 3	BE, DNA, BUC, SA
<input type="checkbox"/> 3169	PDHA1 Comprehensive (Seq & Del/Dup Analysis)	PDH Complex Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3899	PDHB Comprehensive (Seq & Del/Dup Analysis)	PDH Complex Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3894	PDP1 Comprehensive (Seq & Del/Dup Analysis)	PDH Complex Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3924	PDHX Comprehensive (Seq & Del/Dup Analysis)	PDH Complex Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3919	DLAT Comprehensive (Seq & Del/Dup Analysis)	PDH Complex Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3069	POLG Comprehensive (Seq & Del/Dup Analysis)	POLG-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 3384	POLG2 Comprehensive (Seq & Del/Dup Analysis)	POLG2-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 3754	PC Comprehensive (Seq & Del/Dup Analysis)	Pyruvate Carboxylase Deficiency	BE, DNA, BUC, SA
<input type="checkbox"/> 3424	RRM2B Comprehensive (Seq & Del/Dup Analysis)	RRM2B-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 3174	SLC25A4 (ANT1) Comprehensive (Seq & Del/Dup Analysis)	SLC25A4-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 5335	SPG7 Sequence Analysis	Spastic Paraplegia 7, Autosomal Recessive	BE, DNA, BUC, SA
<input type="checkbox"/> 3379	SUCLA2 Comprehensive (Seq & Del/Dup Analysis)	SUCLA2-Related Disorders	BE, DNA, BUC, SA
<input type="checkbox"/> 3394	SUCLG1 Comprehensive (Seq & Del/Dup Analysis)	SUCLG1-Related Disorders	BE, DNA, BUC, SA

* Refer to Sample Specifications Table (Page 8)

Indications on next page

MITOCHONDRIAL TESTING REQUISITION

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

INDICATION FOR TESTING (REQUIRED)
 Clinical management of known diagnosis - Please specify: _____

 Diagnostic Testing - Please complete checklist below.

CENTRAL NERVOUS SYSTEM **VISCERAL** **SENSORY**

- 101 dd Developmental Delay/ ID
- 102 ht Hypotonia
- 103 au Autistic Features
- 104 enc Dementia/ Encephalopathy
- 105 ha Headaches/ Migraines
- 106 stk Stroke, Ischemic Episodes
- 107 atx Ataxia
- 108 sz Intractable/ Refractory/ Myoclonus/Myoclonic Seizures
- 109 pi Perinatal Insult
- 110 ps Pyramidal Signs
- 111 hp Hemiparesis
- 112 spas Spasticity
- 113 dyst Dystonia
- 114 cho Chorea
- 115 sib Self-Injury
- 116 pan Pancreatitis
- 117 dia Diarrhea
- 118 cst Constipation
- 119 cv Cyclic Vomiting
- 120 pob Pseudoobstruction

- 301 gir Gastrointestinal Reflux
- 302 dge Delayed Gastric Emptying
- 303 pan Pancreatitis
- 304 dia Diarrhea
- 305 cst Constipation
- 306 cv Cyclic Vomiting
- 307 pob Pseudoobstruction
- 308 hpf Hepatic Failure
- 309 eta Elevated Transaminases
- 310 rtd Renal Tubular Disease
- 311 ap Apnea/ Hypoventilation
- 312 rsf Respiratory Deficiency/Failure
- 313 ren Renal Dysfunction
- 314 lc Liver Carcinoma
- 315 jau Jaundice
- 316 spm Splenomegaly/Enlarged Spleen
- 317 hpm Hepatomegaly/Enlarged Liver
- 318 hd Hepatic Dysfunction

- 501 rp Retinitis Pigmentosa
- 502 opa Optic Atrophy
- 503 cat Cataract
- 504 hl Sensorineural Hearing Loss
- 505 trv Tortuous Retinal Vessels
- 506 crs Cherry Red Spot/Eye
- 507 co Corneal Opacity
- 508 el Ectopia Lentis
- 509 pp Photophobia

ENDOCRINE

- 601 db Diabetes
- 602 pd Exocrine/Pancreatic Deficiency
- 603 gf Gonadal Failure
- 604 hth Hypothyroidism
- 605 hpt Hypoparathyroidism
- 606 adr Hypo/Hyper-adrenal Function
- 607 ss Short Stature
- 608 adc Adrenal Calcification
- 609 hf Hydrops Fetalis
- 610 pg Pregnant

NEUROMUSCULAR **METABOLITES / METABOLIC** **OTHER CLINICAL**

- 201 pn Peripheral Neuropathy
- 202 exi Exercise Intolerance
- 203 pmw Progressive Muscle Weakness
- 204 smw Static Muscle Weakness
- 205 cr Muscle Cramps after Exercise
- 206 fat Easy Fatigability
- 207 dcmyo Dilated Cardiomyopathy
- 208 hcmyo Hypertrophic Cardiomyopathy
- 209 hb Heart Block
- 210 ar Arrhythmia
- 211 op Ophthalmoparesis, CPEO
- 212 emg Abnormal EMG/NCV
- 213 pto Ptosis
- 214 eh Cardiomegaly/Enlarged Heart

- 400 nbs Abnormal Newborn Screen
- 401 kto Ketosis
- 402 dca Dicarboxylic Aciduria
- 403 la Lactic Acidosis
- 404 csfl High CSF Lactate
- 405 oa Organic Aciduria
- 406 lpc Low Plasma Carnitine
- 407 cpk CPK Abnormalities
- 408 pyr Elevated Pyruvate
- 409 ala Elevated Alanine
- 410 3mg 3-Methylglutaconic Aciduria
- 411 acid Acidosis
- 412 NH3 Hypoammonemia
- 413 hypo Hypoglycemia
- 414 hyper Hyperglycemia
- 415 uco Unusual Color/Odor

- 701 ftt Failure to Thrive
- 702 mce Microcephaly
- 703 sids SIDS/Unexplained Death
- 704 ca Congenital Anomalies
- 705 dys Dysmorphic Features
- 706 id Immunodeficiency
- 707 ma Macrocytic Anemia
- 708 pancytopenia/Bone Marrow Failure
- 709 np Neutropenia
- 710 mc Macrocephaly
- 711 cf Course Features
- 712 sa Skeletal Anomalies
- 713 art Arthritis

MITOCHONDRIAL TESTING REQUISITION

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

INDICATION FOR TESTING - CONTINUED (REQUIRED)
FAMILY HISTORY **ELECTROPHYSIOLOGY**

- | | | | | | |
|------------------------------|-----|----------------------------------|------------------------------|-------|----------------|
| <input type="checkbox"/> 001 | mut | Mutation (Attach details) | <input type="checkbox"/> 801 | baers | Abnormal BAERS |
| <input type="checkbox"/> 002 | mi | Evidence of Maternal Inheritance | <input type="checkbox"/> 802 | vers | Abnormal VERS |
| | | | <input type="checkbox"/> 803 | eeg | Abnormal EEG |

HAIR/SKIN FINDINGS **IMAGING/OTHER STUDIES** **MUSCLE BIOPSY**

- | | | | | | | | | |
|------------------------------|------|------------------------------|------------------------------|------|--------------------------------|------------------------------|------|----------------------------------|
| <input type="checkbox"/> 714 | rash | Rashes with Hypopigmentation | <input type="checkbox"/> 804 | bg | Increased Signal Basal Ganglia | <input type="checkbox"/> 901 | his | Abnormal Histology |
| <input type="checkbox"/> 715 | htii | Hyper Trichosis | <input type="checkbox"/> 805 | dmy | Delayed Myelination | <input type="checkbox"/> 902 | em | Abnormal Ultrastructure |
| <input type="checkbox"/> 716 | alp | Alopecia | <input type="checkbox"/> 806 | cea | Cerebellar Atrophy | <input type="checkbox"/> 903 | enz | Abnormal Respiratory Enzymes |
| <input type="checkbox"/> 717 | ac | Acrocyanosis | <input type="checkbox"/> 807 | pstk | Posterior Stroke | <input type="checkbox"/> 904 | prol | Large Mitochondria/Proliferation |
| <input type="checkbox"/> 718 | ak | Angiokeratoma | <input type="checkbox"/> 808 | leuk | Leukodystrophy | <input type="checkbox"/> 905 | cox | COX Deficiency |
| <input type="checkbox"/> 719 | ic | Ichthyosis | <input type="checkbox"/> 809 | mrs1 | MRS/Lactate Peak | <input type="checkbox"/> 906 | rrf | Ragged Red Fibers |
| | | | <input type="checkbox"/> 810 | mri | Abnormal MRI | | | |

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT		SHIPPING INSTRUCTIONS	SPECIAL NOTES
		(2 YRS - ADULT)	(NEWBORN - 2YRS)		
BE	Blood in EDTA (purple-top)	3 - 5 cc	3 - 5 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
BUC	Buccal Swab	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze. Sample must arrive within 72 hours.	Collected with ORAcollect.Dx (OCD-100) self-collection kit (provided by Baylor Genetics with instructions). It is highly recommended the sample be collected by a healthcare professional.
DNA	DNA, Extracted	10 - 15 µ	10 - 15 µ	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Minimal concentration of 50ng/µ; A260/A280 of ~1.7
L	Liver	50 mg	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.
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.
SFC	Skin Fibroblast Culture	(3) T25 flasks	(3) T25 flasks	Ship at ambient temperature in an insulated container by overnight courier.	Send three (3) T25 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.

INFORMED CONSENT FOR MITOCHONDRIAL TESTING

Patient Last Name _____

Patient First Name _____

MI _____

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

Genetic Sex _____

GENERAL GENETIC TESTING CONSENT

This consent form cannot be used for whole exome sequencing (WES), whole genome sequencing (WGS), biochemical testing, or Huntington disease testing. Consent forms for other tests are located at Baylor Genetics' website (<https://www.baylorgenetics.com/consent/>).

For the purposes of this consent, "I", "my", "you", and "your" can refer to you, your child, your unborn child, or other individual you are the legal representative of.

TEST INFORMATION

Your healthcare provider (doctor, genetic counselor, or other person with medical training) wants to order one or more tests to find a cause for your health issues. This testing can see if there is a cause for your health issues or if there is an increased chance for a health issue to happen to you or your family. Some of these tests look for changes, called variants, in a person's DNA. DNA is our genetic material. You might have testing for variants in one or more genes, specific parts of DNA that are needed for our health. Variants can also be found in other places in the genome (all of the DNA that a person has). Some tests might look for changes in proteins or analytes that cause health issues. The testing ordered will depend on your health issues as well as what is already known about you and your family's genetics. These tests may also explain health issues that your family may have. Even if this test finds the cause of your health issues, this may not help treat or manage those issues.

Before you sign this consent form, you should speak with your healthcare provider. They can help you understand this testing and what it means for your health.

TEST RESULTS

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

- **Positive:** A variant in the DNA was found that is related to your health issues or a health issue that you are at an increased risk of having in the future. These changes that cause disease are also known as pathogenic variants.
- **Negative:** No variants in the DNA were found that are related to your health issues or that would increase your risk of a health issue in the future.
- **Variant of Uncertain Clinical Significance (VUS):** A variant in the DNA was found that we do not know its effect, if any, on health. More testing may be needed for you or your family if a VUS is found that may be associated with your health issues.
- **Secondary and Incidental Findings:** Testing can sometimes find a variant in the DNA not related to the reason for testing. If this result is expected to affect your health, it is called a secondary or incidental finding.

CONSIDERATIONS AND LIMITATIONS

- You should speak with your provider before signing this consent form to understand the risks, benefits, and alternatives to testing.
- Testing may show you have, or are at increased chance of having, a health issue. It may show that you have an increased chance of having a child with a health issue.
- Even if the variant(s) causing your health issues are found, how these issues might progress or improve with treatment might not be known. Affected family members with the same variant might not be affected like you are.
- Depending on the results of testing, more testing may be needed to understand these results. This testing might be needed for you and/or other family members.
- A negative result does not rule out the chance for health issues. Our knowledge of variants and how they cause disease may change over time as we learn more about genetics. Testing has limitations to what it can find as well.
- Certain factors may lead to incorrect results. These include mislabeled samples, incorrect information in the test order, and rare technical errors.
- More sample may be needed from you if the first sample is not sufficient to complete testing.

PATIENT CONFIDENTIALITY AND SAMPLE RETENTION

- If several family members are tested, knowing the correct biological relationships among them is important. In rare cases, testing can show that family members are not related as expected. If this is found, we may contact the provider who ordered your testing.
- If this testing is requested to be cancelled after the order and sample are sent to the laboratory, please see our Test Cancellation Policy at www.baylorgenetics.com/cancel-test/.
- Only Baylor Genetics and its contracted partners will have access to your sample for the ordered testing. Results from testing will only be released to: (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. You have the right to access your test results from Baylor Genetics by providing a written request. You also have the right to request raw data obtained from your sample by providing a written request or HIPAA Authorization Form.
- In rare cases, people with genetic diseases may have problems with health insurance and employment. The U.S. Federal Government has several laws that prohibit discrimination based on test results by health insurance companies and employers. These laws also prohibit unauthorized disclosure of this information. For more information, please visit www.genome.gov/10002077.
- Samples will be kept in the laboratory based on our retention policy. Once testing completes, de-identified sample may be used for test development, quality assurance, and training purposes. Samples are not returned to patients or providers unless requested prior to testing. You and your heirs will not receive payments, benefits, or rights to any resulting products or discoveries.
- The information from your testing may be used in scientific research, publications or presentations, but your specific identity will not be revealed. We may contact your provider to obtain more clinical information about you. Baylor Genetics also performs other types of scientific research and may contact you to see if you would like to be involved.
- Variants found may be submitted to databases. The medical community uses these databases to collect information about how variants might cause disease to improve testing and treatment for patients. An example is ClinVar, a free, public archive of reports on human genetics. Limited clinical information may need to be shared with these databases. In rare cases, this information may be enough to allow you or your family members to be identified.
- For more information on privacy practices at Baylor Genetics, please visit www.baylorgenetics.com/privacy-practices/.

