BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
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 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
			/ /	

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/.

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INFORMED CONSENT FOR AUTISM TESTING

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

USE OF DATA AND SPECIMEN FOR RESEARCH PURPOSES

Biological specimens, test results, and associated information may be used by Baylor Genetics and its research partners for anonymous or coded research purposes, including improving genetic testing, advancing knowledge of genetic conditions, and developing new technologies, including inclusion in de-identified clinical databases, only with the patient's informed consent. Patient data and specimen will not be used for anonymous or coded research, unless authorized by marking below. A patient's decision to decline participation shall not affect their ability to receive testing from Baylor Genetics.

For Oregon patients, please consult the state specific consent form found at www.baylorgenetics.com/forms.

☐ I authorize Baylor Genetics the use of my specimen and de-identified data for research.

FOR SAMPLES FROM NEW YORK STATE RESIDENTS

Samples from New York State residents shall not be included in research without written consent. Samples will not be retained for more than sixty (60) days after receipt by Baylor Genetics, unless authorized by marking below. No tests other than those authorized shall be performed on the samples.

☐ I authorize Baylor Genetics to retain sample(s) longer based on our retention policy for test development, quality assurance, and training purposes.

FINANCIAL AGREEMENT

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. I 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. Please note, some payers may not cover certain screening tests.

If my health insurer does not cover the test or I do not have health insurance, I have received a good faith estimate of the cost for the genetic testing ordered by my provider and agree to pay for the cost of the genetic testing billed to me by Baylor Genetics based on that good faith estimate. More information is available in Baylor Genetics' No Surprises Act and Good Faith Estimate Notice located at https://www.baylorgenetics.com/no-surprises-act/.

A Medicare Advance Beneficiary Notice (ABN) is required for services Medicare identifies as not medically necessary.

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 Name | Patient's Signature | Date Signed (MM / DD / YYYY)

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

*If you are signing on behalf of the patient as the parent(s) and/or person with legal authority to act on behalf of the patient or parent, you may be required to provide evidence of your authority.