



BIOCHEMICAL 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
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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	Zip	City	State	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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Genetic Sex

SAMPLE

SAMPLE TYPE

- | | | | |
|---|--|---|------------------------------------|
| ☐ Blood in ACD (Yellow-top) | ☐ Cerebrospinal Fluid | ☐ Serum (including marble-top, red-top, etc.) | ☐ Skin Biopsy* |
| ☐ Blood in Sodium Heparin (Green-top) | ☐ Cultured Skin Fibroblast | ☐ Urine | |
| ☐ Blood in EDTA (Purple-top) | ☐ Plasma from Sodium Heparin | ☐ Skeletal Muscle | |

DATE OF COLLECTION
(MM/DD/YYYY)

___ / ___ / ___

INDICATION FOR TESTING (REQUIRED)

ICD10 Diagnosis Code(s):

☐ Clinical management of known diagnosis - Please specify:

☐ Clinical History - Please describe:

* 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.



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BIOCHEMICAL TESTS

Note: To order Global MAPS® (Metabolomic Assisted Pathway Screen), please visit baylorgenetics.com/reqs

BIOCHEMICAL PANELS

TEST CODE	TEST NAME	SAMPLE TYPE
☐ 4000	Biochemistry 5-Plex <i>Acylcarnitine Analysis (TC 4300), Amino Acid Analysis (TC 4100), Plasma and Urine Creatine/Guanidinoacetate Determination (TC 4130 & 4260), Organic Acid Screen (TC 4200)</i>	PH + U
☐ 4175	Biochemistry 3-Plex <i>Acylcarnitine Analysis (TC 4300), Amino Acid Analysis (TC 4100), Creatine/Guanidinoacetate Determination (TC 4130)</i>	PH
☐ 4015	Creatine Deficiency Syndromes Panel <i>Creatine Deficiency Syndromes Panel - Plasma and Urine Creatine/Guanidinoacetate Determination (TC 4130 & 4260)</i>	PH + U
☐ 4400	Neonatal and Infantile Seizures Panel <i>Acylcarnitine Analysis (TC 4300), Plasma and CSF Amino Acid Analysis (TC 4100 & 4160), Biotinidase Deficiency (TC 4555), Creatine/Guanidinoacetate Determination (TC 4130), Organic Acid Screen (TC 4200), Pyridoxine-Dependent Seizures Panel (TC 4811), Sulfocysteine Determination (TC 4225)</i>	PH + CSF + SE + U

ANALYTE ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE	TEST CODE	TEST NAME	SAMPLE TYPE
☐ 4300	Acylcarnitine Analysis	PH	☐ 3200	ETC	SM
☐ 4100	Amino Acid Analysis	PH	☐ 4150	Methylmalonic Acid	PH
☐ 4160	Amino Acid Analysis	CSF	☐ 4200	Organic Acid Screen	U
☐ 4240	Amino Acid Analysis	U	☐ 4650	Phenylbutyrate Metabolite Analysis	PH
☐ 4310	Carnitine Determination	PH	☐ 4651	Phenylbutyrate Metabolite Analysis	U
☐ 4130	Creatine/Guanidinoacetate Determination	PH	☐ 4811	Pyridoxine-Dependent Seizures Panel	PH
☐ 4260	Creatine/Guanidinoacetate Determination	U	☐ 4250	Succinylacetone Determination	U
☐ 4627	Cystine Determination	WBC	☐ 4225	Sulfocysteine Determination	U
☐ 3210	ETC	SFC	☐ 4330	Thymidine Determination	PH

ENZYME ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE	TEST CODE	TEST NAME	SAMPLE TYPE
☐ 4536	Argininemia / Arginase Deficiency	RBC	☐ 4569	Tay-Sachs Disease & Sandhoff Disease/ Hexosaminidase A and B	SE
☐ 4555	Biotinidase Deficiency	SE	☐ 4617	Tay-Sachs Disease Carrier Testing Hexosaminidase A	SE
			☐ 4620	Tay-Sachs Disease Carrier Testing Hexosaminidase A	WBC

SAMPLE TYPE KEY:

BA Blood in ACD tube
BH Blood in Sodium Heparin
BE Blood in EDTA tube

CSF Cerebrospinal Fluid
PH Plasma (From Heparin)
RBC Red Blood Cells

SE Serum
SFC Cultured Skin Fibroblast
SM Skeletal Muscle

U Urine
WBC White Blood Cells



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SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT		SHIPPING INSTRUCTIONS	SPECIAL NOTES
		(2 YRS - ADULT)	(NEWBORN - 2 YRS)		
BA	Blood in ACD tube (yellow-top)	3 - 5 cc	3 - 5 cc	Ship at room temperature in an insulated container by overnight courier to arrive within 36 hours of collection. 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.	
CSF	Cerebrospinal Fluid	1 - 2 cc	1 - 2 cc	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Store the specimen frozen at -20°C. Specimen may be stored frozen for up to 7 days.
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.
RBC	Red Blood Cell	3 - 5 cc	3 - 5 cc	Ship at room temperature in an insulated container by overnight courier to arrive within 36 hours of collection. Do not heat or freeze	Draw blood in an ACD (yellow-top) tube(s).
SE	Serum	1 - 2 cc	1 - 2 cc	Ship frozen sample in insulated container, with 3 -5 lbs dry ice, by overnight courier.	Draw blood in a no-additive (red-top) or serum gel (red/gray-top) tube(s) and separate as soon as possible. Store the specimen at -20°C.
SFC	Skin Fibroblast Culture	Two T-25 flasks	Two T-25 flasks	Ship at ambient temperature in an insulated container by overnight courier. Do not heat or freeze.	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.
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.
WBC	White Blood Cell	7 - 10 cc	3 - 5 cc	Ship at room temperature in an insulated container by overnight courier to arrive within 36 hours of collection. Do not heat or freeze	Draw blood in an ACD (yellow-top) tube(s).

INFORMED CONSENT FOR BIOCHEMICAL TESTING

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

BIOCHEMICAL TESTING CONSENT

This consent form can only be used for biochemical 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 change was found that is related to your health issues or that you have an increased chance of having a health issue in the future. You might have a change to the amount and/or function of proteins or analytes.
- **Negative:** No changes were found that are related to your health issues or that would increase your risk of a health issue in the future. The amount and/or function of proteins or analytes appears to be normal.

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. In addition, it may show that you have an increased chance of having a child with a health issue.
- Even if the change(s) in proteins or analytes causing your health issues are found, this may not predict how these issues might progress or improve with treatment. Affected family members with the same change might not be affected like you are.
- Depending on the results of testing, additional testing may be needed to understand any findings. 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 proteins and analytes 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 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 is completed, the 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/.



INFORMED CONSENT FOR BIOCHEMICAL 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.