BAYLOR GENETICS
READY WITH ANSWERS

SHIPPING Baylor Genetics
2450 Holcombe Blvd., Grand Blvd. Receiving Dock
Houston, TX 77021-2024
Phone: 713.798.6555
Fax: 713.798.2787

BIOCHEMICAL TESTING REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM/DD/YY)

Address | Accession # | Hospital/ Medical Record #

Biological Sex: ◯ M ◯ F ◯ Unknown

City | State | Zip | Phone

Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

◆ **ADDITIONAL RECIPIENTS**

Name | Name

Email | Fax | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

☐ **SELF PAYMENT**

◯ Bill Patient For Laboratory Testing

☐ **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/YY) | Address of Insured

Patient's Relationship to Insured | Phone of Insured | City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone | Primary Member Policy # | Primary Member Group #

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 designated insurance carrier any information necessary, including test results, for processing my insurance claim. I also authorize benefits to be payable exclusively to Baylor Genetics. I understand that my insurance carrier may not approve or reimburse my medical genetic services in full or any portion thereof, due to a variety of reasons, including, but not limited to: the contract status of my insurance provider with Baylor Genetics, usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. I understand that I am responsible for 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 Name | Patient's Signature | Date

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

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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

	SAMPLE TYPE	DATE OF COLLECTION (MM/DD/YY)		SAMPLE TYPE	DATE OF COLLECTION (MM/DD/YY)
◯	Blood in ACD (Yellow-top)		◯	Liver	
◯	Blood in EDTA (Purple-top)		◯	Plasma from Sodium Heparin	
◯	Blood in Sodium Heparin (Green-top)		◯	Serum	
◯	Blood Spot		◯	Skeletal Muscle	
◯	Cerebrospinal Fluid		◯	Urine	
◯	Cultured Skin Fibroblast				

INDICATION FOR TESTING (REQUIRED)

☐ Clinical management of known diagnosis - Please specify: _____

☐ Diagnostic Testing - Please complete checklist below.

ICD10 Diagnosis Code(s) _____

◆ CENTRAL NERVOUS SYSTEM

◯	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

◆ VISCERAL

◯	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

◆ ELECTROPHYSIOLOGY

◯	801	baers	Abnormal BAERS
◯	802	vers	Abnormal VERS
◯	803	eeg	Abnormal EEG

◆ SENSORY

◯	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

Indications continued on next page

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INDICATION FOR TESTING (REQUIRED)

NEUROMUSCULAR

◯ 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

IMAGING/OTHER STUDIES

◯ 804	bg	Increased Signal Basal Ganglia
◯ 805	dmy	Delayed Myelination
◯ 806	cea	Cerebellar Atrophy
◯ 807	pstk	Posterior Stroke
◯ 808	leuk	Leukodystrophy
◯ 809	mrsl	MRS/Lactate Peak
◯ 810	mri	Abnormal MRI

METABOLITES / METABOLIC

◯ 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

MUSCLE BIOPSY

◯ 901	his	Abnormal Histology
◯ 902	em	Abnormal Ultrastructure
◯ 903	enz	Abnormal Respiratory Enzymes
◯ 904	prol	Large Mitochondria/Proliferation
◯ 905	cox	COX Deficiency
◯ 906	rrf	Ragged Red Fibers

HAIR/SKIN FINDINGS

◯ 714	rash	Rashes with Hypopigmentation
◯ 715	htii	Hyper Trichosis
◯ 716	alp	Alopecia
◯ 717	ac	Acrocyanosis
◯ 718	ak	Angiokeratoma
◯ 719	ic	Ichthyosis

OTHER CLINICAL

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

FAMILY HISTORY

◯ 001	mut	Mutation (Attach details)
◯ 002	mi	Evidence of Maternal Inheritance

BIOCHEMICAL TESTS

BIOCHEMICAL PANELS

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 4001	Severe Combined Immunodeficiency (SCID) Newborn Screening Follow-Up Panel	BE + BH + BA + U
☐ 4400	Neonatal and Infantile Seizures Panel	PH + CSF + SE + U
☐ 4000	Biochemistry Multi-Plex	PH + U
☐ 4165	Biochemistry 5-Plex	U
☐ 4175	Biochemistry 3-Plex	PH

ANALYTE PANELS

TEST CODE	TEST NAME	SAMPLE TYPE *	TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 4135	Carnitine Biosynthesis Panel	U	☐ 4220	Purine Panel	U
☐ 4145	Carnitine Biosynthesis Panel	PH	☐ 4010	Purine and Pyrimidine Panel	U
☐ 4155	Carnitine Biosynthesis Panel	CSF	☐ 4811	Pyridoxine-Dependent Seizures Panel	PH
☐ 4015	Creatine Deficiency Syndromes Panel	PH + U	☐ 4812	Pyridoxine-Dependent Seizures Panel	CSF
☐ 4340	Polyols	U	☐ 4215	Pyrimidine Panel	U

* Refer to Sample Specifications Table on Page 5

Test list continued on next page

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BIOCHEMICAL TESTS

◆ INDIVIDUAL ANALYTE ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE *	TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 4360	25-Hydroxyvitamin D2 & D3	PH, SE	☐ 4150	Methylmalonic Acid	PH
☐ 4300	Acylcarnitine Analysis	PH	☐ 4651	Phenylbutyrate Metabolite Analysis	U
☐ 4350	Acylglycine Determination	U	☐ 4652	Phenylbutyrate Metabolite Analysis	CSF
☐ 4100	Amino Acid Analysis	PH	☐ 4225	Sulfocysteine Determination	U
☐ 4160	Amino Acid Analysis	CSF	☐ 4200	Organic Acid Screen	U
☐ 4240	Amino Acid Analysis	U	☐ 4210	Orotic Acid/Orotidine Determination **	U
☐ 4310	Carnitine Determination	PH	☐ 4110	Phenylalanine Determination	PH
☐ 4800	Coenzyme Q10 Determination	SM	☐ 4120	Phenylalanine Determination	BSP
☐ 4130	Creatine/Guanidinoacetate Determination	PH	☐ 4650	Phenylbutyrate Metabolite Analysis	PH
☐ 4260	Creatine/Guanidinoacetate Determination	U	☐ 4250	Succinylacetone Determination	U
☐ 4627	White Blood Cell Cystine Determination	BA	☐ 4180	Succinyladenosine	CSF
☐ 4140	Homocysteine Determination	PH	☐ 4330	Thymidine Determination	PH

** The quantitative analysis of Orotidine is temporarily unavailable.

◆ INDIVIDUAL ENZYME ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE *	TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 4509	Adenosine Deaminase Deficiency	BA	☐ 4585	Lowe Syndrome/Phosphatidylinositol Bisphosphate Phosphatase	SFC
☐ 4510	Adenosine Deaminase Deficiency	SFC	☐ 4573	Lesch-Nyhan Disease/Hypoxanthine-Guanine Phospho-ribosyltransferase	SFC
☐ 4511	Adenosine Deaminase Deficiency	BA	☐ 4603	Mucolipidosis I (Sialidosis)/Sialidase	SFC
☐ 4535	Argininemia / Arginase Deficiency	L	☐ 4582	Ornithine Transcarbamylase Deficiency	L
☐ 4536	Argininemia / Arginase Deficiency	BA	☐ 4592	Purine Nucleoside Phosphorylase Deficiency (Red Blood Cells)	BA
☐ 4523	Argininosuccinic Aciduria/Argininosuccinate Lyase Deficiency	L	☐ 4593	Purine Nucleoside Phosphorylase Deficiency	SFC
☐ 4524	Argininosuccinic Aciduria/Argininosuccinate Lyase Deficiency	BA	☐ 4594	Purine Nucleoside Phosphorylase Deficiency (White Blood Cells)	BA
☐ 4525	Argininosuccinic Aciduria/Argininosuccinate Lyase Deficiency	SFC	☐ 4569	Tay-Sachs Disease & Sandhoff Disease/ Hexosaminidase A and B	SE
☐ 4514	Aspartylglucosaminuria/ Aspartylglucosiminidase Deficiency	SFC	☐ 4617	Tay-Sachs Carrier Testing & Sandhoff Disease/ Hexosaminidase A and B	SE
☐ 4555	Biotidinase Deficiency	SE	☐ 4620	Tay-Sachs Carrier Testing & Sandhoff Disease/ Hexosaminidase A and B	BA
☐ 4561	Carbamoyl Phosphate Synthetase I Deficiency	L	☐ 4502	Wolman Disease/Cholesteryl Ester Storage Disease/Lysosomal Acid Lipase Analysis	L
☐ 4544	Citrullinemia/Arginosuccinate Synthetase Deficiency, Type 1	L	☐ 4503	Wolman Disease/Cholesteryl Ester Storage Disease/Lysosomal Acid Lipase Analysis	SFC
☐ 4545	Citrullinemia/Arginosuccinate Synthetase Deficiency, Type 1	SFC	☐ 4504	Wolman Disease/Cholesteryl Ester Storage Disease/Lysosomal Acid Lipase Analysis	BA
☐ 4548	GM1 Gangliosidosis (Morquio B, MPS IVB)/Beta-Galactosidase	SFC	☐ 4614	X-Linked Ichthyosis/Steroid Sulfatase	SFC
☐ 4549	GM1 Gangliosidosis (Morquio B, MPS IVB)/Beta-Galactosidase	BA	☐ 4615	X-Linked Ichthyosis/Steroid Sulfatase	BA

* Refer to Sample Specifications Table on Page 5

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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.	
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.	
BSP	Blood Spot	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier to arrive within 36 hours of collection. Do not heat or freeze.	Dried blood spot specimens should be collected by carefully applying a few drops of blood, freshly drawn by finger stick with a lancet from children or adults, or by heel stick with a lancet from infants, onto specially manufactured absorbent specimen collection (filter) paper. The blood should be allowed to thoroughly saturate the paper and air dried for a minimum of 3 hours. Caked or clotted specimens are not acceptable and should not be shipped. Clearly label all samples with patient name, date of birth, and date of sample collection. Samples not clearly labeled will not be accepted for analysis.
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.
L	Liver	10 - 15 mg	10 - 15 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.
SE	Serum	1 - 2 cc	1 - 2 cc	Ship frozen on dry ice in an insulated container 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.	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.
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.