

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 #	
City		State	Zip	Phone	Biological Sex: <input type="radio"/> M <input type="radio"/> F <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	Name
Email	Email
Fax	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
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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/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
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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
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ETHNICITY

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

SAMPLE

SAMPLE TYPE	DATE OF COLLECTION (MM/DD/YY)	SAMPLE TYPE	DATE OF COLLECTION (MM/DD/YY)
<input type="radio"/> Blood in ACD (Yellow-top)		<input type="radio"/> Liver	
<input type="radio"/> Blood in EDTA (Purple-top)		<input type="radio"/> Plasma from Sodium Heparin	
<input type="radio"/> Blood in Sodium Heparin (Green-top)		<input type="radio"/> Serum	
<input type="radio"/> Blood Spot		<input type="radio"/> Skeletal Muscle	
<input type="radio"/> Cerebrospinal Fluid		<input type="radio"/> Urine	
<input type="radio"/> 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

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

VISCERAL

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

ELECTROPHYSIOLOGY

<input type="radio"/> 801	baers	Abnormal BAERS
<input type="radio"/> 802	vers	Abnormal VERS
<input type="radio"/> 803	eeg	Abnormal EEG

SENSORY

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

ENDOCRINE

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

Indications continued on next page

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INDICATION FOR TESTING (REQUIRED)
NEUROMUSCULAR

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

IMAGING/OTHER STUDIES

<input type="radio"/>	804	bg	Increased Signal Basal Ganglia
<input type="radio"/>	805	dmy	Delayed Myelination
<input type="radio"/>	806	cea	Cerebellar Atrophy
<input type="radio"/>	807	pstk	Posterior Stroke
<input type="radio"/>	808	leuk	Leukodystrophy
<input type="radio"/>	809	mrs1	MRS/Lactate Peak
<input type="radio"/>	810	mri	Abnormal MRI

METABOLITES / METABOLIC

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

MUSCLE BIOPSY

<input type="radio"/>	901	his	Abnormal Histology
<input type="radio"/>	902	em	Abnormal Ultrastructure
<input type="radio"/>	903	enz	Abnormal Respiratory Enzymes
<input type="radio"/>	904	prol	Large Mitochondria/Proliferation
<input type="radio"/>	905	cox	COX Deficiency
<input type="radio"/>	906	rrf	Ragged Red Fibers

HAIR/SKIN FINDINGS

<input type="radio"/>	714	rash	Rashes with Hypopigmentation
<input type="radio"/>	715	htii	Hyper Trichosis
<input type="radio"/>	716	alp	Alopecia
<input type="radio"/>	717	ac	Acrocyanosis
<input type="radio"/>	718	ak	Angiokeratoma
<input type="radio"/>	719	ic	Ichthyosis

OTHER CLINICAL

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

FAMILY HISTORY

<input type="radio"/>	001	mut	Mutation (Attach details)
<input type="radio"/>	002	mi	Evidence of Maternal Inheritance

BIOCHEMICAL TESTS
BIOCHEMICAL PANELS

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

ANALYTE PANELS

TEST CODE	TEST NAME	SAMPLE TYPE *	TEST CODE	TEST NAME	SAMPLE TYPE *
<input type="checkbox"/> 4135	Carnitine Biosynthesis Panel	U	<input type="checkbox"/> 4220	Purine Panel	U
<input type="checkbox"/> 4145	Carnitine Biosynthesis Panel	PH	<input type="checkbox"/> 4010	Purine and Pyrimidine Panel	U
<input type="checkbox"/> 4155	Carnitine Biosynthesis Panel	CSF	<input type="checkbox"/> 4811	Pyridoxine-Dependent Seizures Panel	PH
<input type="checkbox"/> 4015	Creatine Deficiency Syndromes Panel	PH + U	<input type="checkbox"/> 4812	Pyridoxine-Dependent Seizures Panel	CSF
<input type="checkbox"/> 4340	Polyols	U	<input type="checkbox"/> 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 *
<input type="checkbox"/> 4360	25-Hydroxyvitamin D2 & D3	PH, SE	<input type="checkbox"/> 4150	Methylmalonic Acid	PH
<input type="checkbox"/> 4300	Acylcarnitine Analysis	PH	<input type="checkbox"/> 4651	Phenylbutyrate Metabolite Analysis	U
<input type="checkbox"/> 4350	Acylglycine Determination	U	<input type="checkbox"/> 4652	Phenylbutyrate Metabolite Analysis	CSF
<input type="checkbox"/> 4100	Amino Acid Analysis	PH	<input type="checkbox"/> 4225	Sulfocysteine Determination	U
<input type="checkbox"/> 4160	Amino Acid Analysis	CSF	<input type="checkbox"/> 4200	Organic Acid Screen	U
<input type="checkbox"/> 4240	Amino Acid Analysis	U	<input type="checkbox"/> 4210	Orotic Acid/Orotidine Determination **	U
<input type="checkbox"/> 4310	Carnitine Determination	PH	<input type="checkbox"/> 4110	Phenylalanine Determination	PH
<input type="checkbox"/> 4800	Coenzyme Q10 Determination	SM	<input type="checkbox"/> 4120	Phenylalanine Determination	BSP
<input type="checkbox"/> 4130	Creatine/Guanidinoacetate Determination	PH	<input type="checkbox"/> 4650	Phenylbutyrate Metabolite Analysis	PH
<input type="checkbox"/> 4260	Creatine/Guanidinoacetate Determination	U	<input type="checkbox"/> 4250	Succinylacetone Determination	U
<input type="checkbox"/> 4627	White Blood Cell Cystine Determination	BA	<input type="checkbox"/> 4180	Succinyladenosine	CSF
<input type="checkbox"/> 4140	Homocysteine Determination	PH	<input type="checkbox"/> 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 *
<input type="checkbox"/> 4509	Adenosine Deaminase Deficiency	BA	<input type="checkbox"/> 4582	Ornithine Transcarbamylase Deficiency	L
<input type="checkbox"/> 4510	Adenosine Deaminase Deficiency	SFC	<input type="checkbox"/> 4592	Purine Nucleoside Phosphorylase Deficiency (Red Blood Cells)	BA
<input type="checkbox"/> 4511	Adenosine Deaminase Deficiency	BA	<input type="checkbox"/> 4593	Purine Nucleoside Phosphorylase Deficiency	SFC
<input type="checkbox"/> 4535	Argininemia / Arginase Deficiency	L	<input type="checkbox"/> 4594	Purine Nucleoside Phosphorylase Deficiency (White Blood Cells)	BA
<input type="checkbox"/> 4536	Argininemia / Arginase Deficiency	BA	<input type="checkbox"/> 4569	Tay-Sachs Disease & Sandhoff Disease/ Hexosaminidase A and B	SE
<input type="checkbox"/> 4523	Argininosuccinic Aciduria/Argininosuccinate Lyase Deficiency	L	<input type="checkbox"/> 4617	Tay-Sachs Carrier Testing & Sandhoff Disease/ Hexosaminidase A and B	SE
<input type="checkbox"/> 4524	Argininosuccinic Aciduria/Argininosuccinate Lyase Deficiency	BA	<input type="checkbox"/> 4620	Tay-Sachs Carrier Testing & Sandhoff Disease/ Hexosaminidase A and B	BA
<input type="checkbox"/> 4525	Argininosuccinic Aciduria/Argininosuccinate Lyase Deficiency	SFC	<input type="checkbox"/> 4502	Wolman Disease/Cholesteryl Ester Storage Disease/Lysosomal Acid Lipase Analysis	L
<input type="checkbox"/> 4555	Biotinidase Deficiency	SE	<input type="checkbox"/> 4503	Wolman Disease/Cholesteryl Ester Storage Disease/Lysosomal Acid Lipase Analysis	SFC
<input type="checkbox"/> 4561	Carbamoyl Phosphate Synthetase I Deficiency	L	<input type="checkbox"/> 4504	Wolman Disease/Cholesteryl Ester Storage Disease/Lysosomal Acid Lipase Analysis	BA
<input type="checkbox"/> 4544	Citrullinemia/Argininosuccinate Synthetase Deficiency, Type 1	L	<input type="checkbox"/> 4614	X-Linked Ichthyosis/Steroid Sulfatase	SFC
<input type="checkbox"/> 4545	Citrullinemia/Argininosuccinate Synthetase Deficiency, Type 1	SFC	<input type="checkbox"/> 4615	X-Linked Ichthyosis/Steroid Sulfatase	BA
<input type="checkbox"/> 4585	Lowe Syndrome/Phosphatidylinositol Bisphosphate Phosphatase	SFC			
<input type="checkbox"/> 4573	Lesch-Nyhan Disease/Hypoxanthine-Guanine Phospho-ribosyltransferase	SFC			

* Refer to Sample Specifications Table on Page 5

BIOCHEMICAL TESTING REQUISITION

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. 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.