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

INHERITED EYE DISORDERS 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) _____

INDICATION FOR TESTING (REQUIRED)

☐ Symptomatic (Summarize below) ☐ Symptomatic with Family History

☐ Asymptomatic

- ◯ Population Screening
- ◯ Positive Family History

Disease | Gene | Variant

ICD10 Diagnosis Code(s): _____

SAMPLE

◆ **SAMPLE TYPE**

- ◯ Blood in EDTA-tube (purple-top)
- ◯ Blood in Heparin-tube (green-top)
- ◯ DNA
- ◯ Other (Specify)
- ◯ Liver
- ◯ Saliva
- ◯ Skeletal Muscle
- ◯ Tissue

Note: Blood should not be sent from patients who have had a bone marrow transplant or recent blood transfusion

Date of Collection (MM/DD/YY)

◆ **TESTING OPTIONS**

☐ Targeted Sequencing for Known Familial Mutation
(If selected, specify test code and gene below and complete section to the right)

Test Code | Gene

☐ Full Gene Sequencing

☐ Deletion/ Duplication Analysis

FOR TARGETED TESTING SELECTION ONLY

Proband Last Name | Proband First Name

Date of Birth (MM/DD/YY) | Relationship of Proband to Patient

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.

INHERITED EYE DISORDERS TESTS

◆ **CYTOGENETIC TESTS**

TEST CODE	TEST NAME	SAMPLE TYPE *	SPECIFY GENE OF INTEREST	SPECIFY REGION OF INTEREST
☐ 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE + BH		
☐ 8655	Chromosomal Microarray Analysis (CMA) - HR	BE + BH		

◆ **MITOCHONDRIAL DNA (mtDNA) MUTATION SCREENS**

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 2010	Advanced mtDNA Point Mutations and Deletions by Massively Parallel Sequencing (BCM-MitomeNGS^{SM})	BE, SM, T
☐ 2055	Comprehensive mtDNA Analysis by Massively Parallel Sequencing (BCM-MitomeNGS^{SM})	BE, DNA, L SM, T

* Refer to Sample Specifications Table (page 5)

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INHERITED EYE DISORDERS TESTS

◆ MASSIVELY PARALLEL SEQUENCING (BCM-MitomeNGS[SM]) PANELS

TEST CODE	TEST NAME	SAMPLE TYPE *	TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 20100	Albinism Panel (13 genes)	BE, DNA	☐ 5255	Primary Open Angle Glaucoma Panel (*MYOC, OPTN*)	BE, DNA
☐ 5260	Developmental Glaucoma Panel (8 genes)	BE, DNA	☐ 2140	Progressive External Ophthalmoplegia Panel (10 genes)	BE, DNA
☐ 5250	Familial Exudative Vitreoretinopathy Panel (*FZD4, LRP5, NDP,* and *TSPAN12)*	BE, DNA	☐ 2190	Retinitis Pigmentosa + RPGR orf15 by NGS (66 genes)	BE, DNA
☐ 5090	Leber Congential Amaurosis Panel (19 genes)	BE, DNA	☐ 2195	Usher Syndrome Panel (9 genes)	BE, DNA

◆ DNA COPY NUMBER ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE *	SPECIFY GENE OF INTEREST
☐ 2000	MitoMet®Plus aCGH Analysis	BE	
☐ 2001	Oligonucleotide Targeted Array Analysis (Single Target Gene)	BE	
☐ 2003	Oligonucleotide Targeted Array Analysis (Up to 5 Target Genes)	BE	

◆ 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 *
☐ 6603	*ABCA4* Comprehensive (Seq. & Del/Dup Analysis)	ABCA4-Related Disorders	BE
☐ 2924	*BEST1* Comprehensive (Seq. & Del/Dup Analysis)	BEST1-Related Disorders	BE
☐ 2419	*CEP290* Comprehensive (Seq. & Del/Dup Analysis)	CEP290-Related Disorders	BE
☐ 6655	*CDH23* Sequence Analysis	CDH23-Related Disorders	BE
☐ 6660	*CLRN1* Sequence Analysis	CLRN1-Related Disorders	BE
☐ 7521	*COL2A1* Comprehensive (Seq. & Del/Dup Analysis)	COL2A1-Related Disorders	BE
☐ 2389	*CDHR1* Comprehensive (Seq. & Del/Dup Analysis)	Cone-Rod Dystrophy 15	BE
☐ 2849	*CRB1* Comprehensive (Seq. & Del/Dup Analysis)	CRB1-Related Disorders	BE
☐ 2954	*CRX* Comprehensive (Seq. & Del/Dup Analysis)	CRX-Related Disorders	BE
☐ 29215	*CYP1B1* Sequence Analysis by NGS	CYP1B1-Related Disorders	BE, DNA
☐ 29260	*TSPAN12* Sequence Analysis by NGS	Exudative Vitreoretinopathy 5	BE, DNA
☐ 29255	*FZD4* Sequence Analysis by NGS	FZD4-Related Disorders	BE, DNA
☐ 2439	*GUCY2D* Comprehensive (Seq. & Del/Dup Analysis)	GUCY2D-Related Disorders	BE
☐ 5280	*OAT* Sequence Analysis	Gyrate Atrophy of Choroid and Retina	BE
☐ 2789	*IMPDH1* Comprehensive (Seq. & Del/Dup Analysis)	IMPDH1-Related Disorders	BE
☐ 2394	*LCA5* Comprehensive (Seq. & Del/Dup Analysis)	LCA5-Related Disorders	BE

* Refer to Sample Specifications Table (page 5)

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◆ **SINGLE GENE ANALYSIS CONTINUED**

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE *
☐ 5084	*CABP4* Comprehensive (Seq. & Del/Dup Analysis)	Leber Congenital Amaurosis	BE
☐ 5069	*IQCB1* Comprehensive (Seq. & Del/Dup Analysis)	Leber Congenital Amaurosis	BE
☐ 6039	*OCRL* Sequence Analysis	Lowe Syndrome	BE
☐ 2839	*LRAT* Comprehensive (Seq. & Del/Dup Analysis)	LRAT-Related Disorders	BE
☐ 29265	*LRP5* Sequence Analysis by NGS	LRP5-Related Disorders	BE, DNA
☐ 2409	*MFRP* Comprehensive (Seq. & Del/Dup Analysis)	Microphththalmia, Isolated 5 Disorder	BE
☐ 29270	*NDP* Sequence Analysis by NGS	NDP-Related Disorders	BE, DNA
☐ 6083	X-Linked, *GPR143* Comprehensive (Seq. & Del/Dup Analysis)	Oculocutaneous Albinism	BE
☐ 3469	Type 1, *OPA1* Comprehensive (Seq. & Del/Dup Analysis)	Optic Atrophy	BE
☐ 3529	Type 3, *OPA3* Comprehensive (Seq. & Del/Dup Analysis)	Optic Atrophy	BE
☐ 29250	*OPTN* Sequence Analysis by NGS	OPTN-Related Disorders	BE, DNA
☐ 29235	*PAX6* Sequence Analysis by NGS	PAX6-Related Disorders	BE, DNA
☐ 29240	*PITX2* Sequence Analysis by NGS	PITX2-Related Disorders	BE, DNA
☐ 29220	*PITX3* Sequence Analysis by NGS	PITX3-Related Disorders	BE, DNA
☐ 2414	*ABHD12* Comprehensive (Seq. & Del/Dup Analysis)	Polyneuropathy, Hearing Loss, Ataxia, Retinitis Pigmentosa, and Cataract Disorder	BE
☐ 29245	*MYOC* Sequence Analysis by NGS	Primary Open Angle Glaucoma 1A	BE, DNA
☐ 2959	*RDH12* Comprehensive (Seq. & Del/Dup Analysis)	RDH12-Related Disorders	BE
☐ 2964	C2orf71 Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2764	*CA4* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2944	*CNGB1* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2969	*DHDDS* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2974	*EYS* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2994	*FAM161A* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2769	*FSCN2* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2454	*IMPG2* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2984	*MERTK* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2459	*PDE6B* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2399	*PROM1* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2799	*PRPF31* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2939	*PRPH2* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2479	*RGR* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2474	*RLBP1* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2814	*ROM1* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2449	*RP2* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2359	*RPGR* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2484	*SAG* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE
☐ 2894	*TOPORS* Comprehensive (Seq. & Del/Dup Analysis)	Retinitis Pigmentosa	BE

* Refer to Sample Specifications Table (page 5)

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◆ SINGLE GENE ANALYSIS CONTINUED

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE *
☐ 29540	*RS1* Sequence Analysis by NGS	Retinoschisis	BE, DNA
☐ 2934	*RPE65* Comprehensive (Seq. & Del/Dup Analysis)	RPE65-Related Disorders	BE, DNA
☐ 2354	*RPGRIP1* Comprehensive (Seq. & Del/Dup Analysis)	RPGRIP1-Related Disorders	BE, DNA
☐ 2899	*PRKCG* Comprehensive (Seq. & Del/Dup Analysis)	Spinocerebellar Ataxia 14 (SCA)	BE, DNA
☐ 6650	*USH2A* Sequence Analysis	USH2A-Related Disorders	BE, DNA
☐ 2379	Type 1C, *USH1C* Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
☐ 2374	Type 1F, *PCDH15* Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
☐ 2369	Type 2C, *GPR98* Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
☐ 2364	Type 2D, *DFNB31* Comprehensive (Seq. & Del/Dup Analysis)	Usher Syndrome	BE, DNA
☐ 29230	*VSX1* Sequence Analysis	VSX1-Related Disorders	BE, DNA

* Refer to Sample Specifications Table below

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT (2 yrs - Adult)	RECOMMENDED AMOUNT (Newborn - 2 yrs)	SHIPPING INSTRUCTIONS	SPECIAL NOTES
BE	Blood in EDTA tube (purple-top)	10 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	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.
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.
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.
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.