CTGT Genetic Testing | HNL Lab Medicine

GENETIC CARRIER SCREENING TEST REQUISITION FORM

Please print clearly and provide all requested information. CTGT cannot initiate testing unless this information is provided.

ORDERING PHYSICIAN REQUIRED

CLIA# 39D1027912
CAP# 7 190738
6575 Snowdrift Road | Suite 106 | Allentown, PA 18106
T: +1 484-244-2900 | F: +1 484-244-2904 | **CTGT.net**

369919

CONSOLIDATED GRAPHIC COMMUNICATIONS (610) 566-1515

PATIENT INFORMATION

☐ FEMALE PATIENT ☐ MALE PATIENT

PATIENT NAME — LAST, FIRST, MI		LAST 4 DIGITS OF SOCIAL SECURITY NO.
DATE OF BIRTH (MM/DD/YYYY)	TELEPHONE NUMBER	
STREET NUMBER	STREET NAME	APT NUMBER
CITY	STATE	ZIP

FAMILY BACKGROUND

Does the patient have a known family history of a known genetic disease? ☐ Yes ☐ No

If yes, include relevant family history: _____

_____

Other family history of a genetic disorder (list specific conditions and person affected):

_____

Patient Ethnicity:

☐ Asian ☐ African American ☐ White/Caucasian ☐ French Canadian/Cajun ☐ Hispanic ☐ Jewish, Ashkenazi ☐ Jewish, non-Ashkenazi ☐ Middle Eastern ☐ Native American ☐ Other: _____

NAME OF LEGAL GUARDIAN IF PATIENT IS A MINOR

SPECIMEN INFORMATION

ORDER DATE	COLLECTION DATE	COLLECTION TIME ☐ AM ☐ PM
SPECIMEN TYPE	SPECIMEN SOURCE	
DATE AND TIME OF RECEIPT (To be completed by HNL) ☐ AM ☐ PM		

ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I am responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031 (b)(4), and/ or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim. I authorize information to be shared with my partner if also undergoing testing.

☐ I AUTHORIZE the laboratory to retain and use my de-identified specimen and test data (where all information that could link me to the specimen or data has been removed) for research and/or help develop new products or services, in compliance with applicable laws.

☐ I DO NOT AUTHORIZE the laboratory to retain and use my de-identified specimen and test data as described above. If signature is present but box is not checked, consent is implied. All leftover specimens from New York State will be destroyed within 60 days.

PATIENT SIGNATURE DATE (MM/DD/YYYY)

REQUIRED: X _____ _____

PAYMENT INFORMATION

☐ **SELF PAY** (Also required for all insurance cases — please see "INSURANCE" below)

☐ CHECK ☐ M.O. Please make check or money order payable to HNL.

☐ **INSURANCE** In addition to completing the information below, be sure to provide a clear copy of both the front and back of your insurance card, and sign below.

NAME OF INSURED	RELATIONSHIP TO PATIENT	
INSURANCE ID NUMBER	GROUP NUMBER	
PRE-AUTHORIZATION NUMBER	DATE(S) AUTHORIZATION VALID	INSURANCE COMPANY PHONE NUMBER

PATIENT SIGNATURE DATE (MM/DD/YYYY)

REQUIRED: X _____ _____

☐ **INSTITUTIONAL BILLING**

FACILITY NAME	CONTACT PERSON	
TELEPHONE NUMBER	FAX NUMBER	
STREET NUMBER	STREET NAME	APT NUMBER
CITY	STATE	ZIP
E-MAIL		

Refer to HNL lab handbook (at **www.HNL.com**) for a complete test listing of panels, collection requirements and other methodologies available for testing, special instructions, and testing algorithms.

REPORTING INFORMATION

REFERRAL SOURCE

REFERRED BY	NPI NUMBER
GENETIC COUNSELOR	
INSTITUTION	
TELEPHONE NUMBER	FAX NUMBER
E-MAIL	
STREET NUMBER / STREET NAME	SUITE NUMBER
CITY	STATE / ZIP

ADDITIONAL REPORTS

REFERRING LAB	REFERRING LAB ID#
CONTACT PERSON	
TELEPHONE NUMBER	FAX NUMBER
E-MAIL	
STREET NUMBER / STREET NAME	SUITE NUMBER
CITY	STATE / ZIP

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.

☐ The patient has completed pre-testing genetic counseling.

PROVIDER SIGNATURE DATE (MM/DD/YYYY)

REQUIRED: X _____ _____

ICD-10 CODES (Required):

CLINICAL DIAGNOSIS:	AGE AT INITIAL PRESENTATION:

CARRIER SCREENING TESTS (See disorder lists on reverse side)

PANEL TESTING

☐ 6000 Common Carrier Screening Panel

☐ 6001 Extended Carrier Screening Panel

SINGLE DISORDER TESTING

☐ 6002 Cystic fibrosis

☐ 6003 Duchenne muscular dystrophy, Becker muscular dystrophy, Cardiomyopathy, dilated, 3B

☐ 6004 Fragile X syndrome, Fragile X tremor/ataxia syndrome, Premature ovarian failure 1

☐ 6005 Thalassemias, alpha-

☐ 6006 Sickle cell anemia, Thalassemia, beta-

☐ 6007 Phenylketonuria

☐ 6008 Spinal muscular atrophy

Federally funded plan beneficiaries may select a lab of their choice.

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COMMON CARRIER SCREENING PANEL

DISORDERS	GENES
Canavan disease	ASPA
Maple syrup urine disease, type Ia	BCKDHA
Bloom syndrome	BLM
Cystic fibrosis	CFTR
Duchenne muscular dystrophy Becker muscular dystrophy Cardiomyopathy, dilated, 3B	DMD
Fanconi anemia, complementation group C	FANCC
Fragile X syndrome Fragile X tremor/ataxia syndrome Premature ovarian failure 1	FMR1
Gaucher disease, perinatal lethal Gaucher disease, type I Gaucher disease, type II Gaucher disease, type III Gaucher disease, type IIIC	GBA
Thalassemias, alpha-	HBA1 / HBA2
Sickle cell anemia Thalassemia, beta-	HBB
Tay-Sachs disease	HEXA
Dysautonomia, familial	IKBKAP
Mucolipidosis IV	MCOLN1
Phenylketonuria	PAH
Spinal muscular atrophy	SMN1 / SMN2
Niemann-Pick disease, type A Niemann-Pick disease, type B	SMPD1

CARRIER SCREENING IN SINGLE GENE

DISORDERS	GENES
Cystic fibrosis	CFTR
Duchenne muscular dystrophy, Becker muscular dystrophy, Cardiomyopathy, dilated, 3B	DMD
Fragile X syndrome, Fragile X tremor/ataxia syndrome, Premature ovarian failure 1	FMR1
Thalassemias, alpha-	HBA1 / HBA2
Sickle cell anemia, Thalassemia, beta-	HBB
Phenylketonuria	PAH
Spinal muscular atrophy	SMN1 / SMN2

EXTENDED CARRIER SCREENING PANEL

DISORDERS	GENES	INHERITANCE
Acyl-CoA dehydrogenase, medium chain, deficiency of	ACADM	AR
Metachromatic leukodystrophy	ARSA	AR
Mucopolysaccharidosis type VI (Maroteaux-Lamy)	ARSB	AR
Canavan disease	ASPA	AR
Citrullinemia	ASS1	AR
Maple syrup urine disease, type Ia	BCKDHA	AR
Maple syrup urine disease, type Ib	BCKDHB	AR
Bloom syndrome	BLM	AR
Biotinidase deficiency	BTD	AR
Cystic fibrosis Congenital bilateral absence of vas deferens	CFTR	AR
Smith-Lemli-Opitz syndrome	DHCR7	AR
Duchenne muscular dystrophy Becker muscular dystrophy Cardiomyopathy, dilated, 3B	DMD	XLR XLR XL
Fanconi anemia, complementation group C	FANCC	AR
Fragile X syndrome Fragile X tremor/ataxia syndrome Premature ovarian failure 1	FMR1	XL
Glycogen storage disease Ia	G6PC	AR
Glycogen storage disease II (POMPE DISEASE)	GAA	AR
Krabbe disease	GALC	AR
Galactose epimerase deficiency	GALE	AR
Galactokinase deficiency with cataracts	GALK1	AR
Galactosemia	GALT	AR
Cerebral creatine deficiency syndrome 2	GAMT	AR
Cerebral creatine deficiency syndrome 3	GATM	AR
Gaucher disease, perinatal lethal Gaucher disease, type I Gaucher disease, type II Gaucher disease, type III Gaucher disease, type IIIC	GBA	AR
Fabry disease	GLA	XL
Thalassemias, alpha-	HBA1 / HBA2	—
Sickle cell anemia Thalassemia, beta-	HBB	AR —
Tay-Sachs disease	HEXA	AR
Hemochromatosis	HFE	AR
Mucopolysaccharidosis II	IDS	XLR
Mucopolysaccharidosis Ih Mucopolysaccharidosis Ih/s Mucopolysaccharidosis Is	IDUA	AR
Dysautonomia, familial	IKBKAP	AR
Isovaleric acidemia	IVD	AR
Mucolipidosis IV	MCOLN1	AR
Methylmalonic aciduria and homocystinuria, cblC type	MMACHC	AR
Ornithine transcarbamylase deficiency	OTC	XLR
Phenylketonuria	PAH	AR
Glycogen storage disease, type IXa1/a2	PHKA2	XLR
Glycogen storage disease IXc	PHKG2	AR
Polycystic kidney disease 4, with or without hepatic disease	PKHD1	AR
Glycogen storage disease VI	PYGL	AR
Glycogen storage disease Ib Glycogen storage disease Ic	SLC37A4	AR
Cerebral creatine deficiency syndrome 1	SLC6A8	XLR
Spinal muscular atrophy	SMN1 / SMN2	AR
Niemann-Pick disease, type A Niemann-Pick disease, type B	SMPD1	AR
Multiple sulfatase deficiency	SUMF1	AR

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NUMBER OF TESTS ORDERED: