



Insurance and Advance Pay Test Requisition

For Specimen Collection Service, Please Fax this Test Requisition to 1.610.271.6085

Client Services is available Monday through Friday from 8:30 AM to 7:00 PM EST at 1.800.394.4493, option 2

NOTE: Please complete each section in full. Missing information will delay your patient's testing.

Patient Information

Patient Name _____

Patient ID# (if available) _____

Date of Birth _____ Sex designated at birth: ☐ Male ☐ Female

Street address _____

City, State, Zip _____

Mobile phone #1 _____ Other Phone #2 _____

Patient email _____

Language spoken if other than English _____

Ordering Account Information

Ordering physician name: _____

Address _____

City, State, Zip _____

Phone _____ Fax _____ Email _____

NPI# _____ Athena Account # (if assigned) _____

Reporting preference: ☐ Fax ☐ Email

Send additional report copies to:

Clinician/Facility _____

NPI# or CLIA _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Email _____

Test Information

Consult test list for test code, name and acceptable specimen options. Specimen requirements are referenced at the top of the test list.

Call Client Services at 1.800.394.4493, option 2 for additional details.

ICD-10 Codes (required for billing insurance): _____

Test Code	Test Name

NOTE: Please complete each section in full. Missing information will delay your patient's testing.**Clinical Information**

Clinical diagnosis: _____

Age at Initial Presentation: _____

Ancestral Background (check all that apply):

- | | | | |
|------------------------------------|--|---|---|
| <input type="checkbox"/> African | <input type="checkbox"/> Asian: East | <input type="checkbox"/> Asian: Southeast | <input type="checkbox"/> Central/South American |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Native American | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Asian: Indian |
| <input type="checkbox"/> Caribbean | <input type="checkbox"/> European | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Pacific Islander |

Other: _____

Indications for genetic testing (please check one):

- | | | |
|---|---|---|
| <input type="checkbox"/> Diagnostic (symptomatic) | <input type="checkbox"/> Predictive (asymptomatic) | <input type="checkbox"/> Prenatal (Contact Athena prior to sending) |
| <input type="checkbox"/> Carrier | <input type="checkbox"/> Family testing/single site | |

Relationship to Proband: _____

If performed at Athena, provide relative's accession # _____.

If performed at another lab, a copy of the relative's report is required.

Please attach detailed medical records and family history information.**Specimen Information****Specimen Type:** **Date sample obtained:** _____/_____/_____

- | | | | |
|--------------------------------------|--------------------------------|--|--|
| <input type="checkbox"/> Whole Blood | <input type="checkbox"/> Serum | <input type="checkbox"/> Cerebrospinal Fluid (CSF) | <input type="checkbox"/> CVS: Cultured |
|--------------------------------------|--------------------------------|--|--|

- | | |
|---|---|
| <input type="checkbox"/> Amniotic Fluid: Cultured | <input type="checkbox"/> Saliva (Not available for all tests) |
|---|---|

☐ DNA* source: _____ Concentration _____ ug/ml

*DNA must be extracted at a CLIA-certified or a laboratory meeting equivalent requirements (as determined by CAP and/or CMS).

☐ Other** source (provide specimen type): _____**Contact Athena **prior to sending** specimen types not listed above.If not collected same day as shipped, how was sample stored? ☐ Room temp ☐ Refrigerated ☐ FrozenHistory of ☐ blood transfusion or ☐ bone marrow transplant? ☐ Yes ☐ No

Date of most recent transfusion/transplant: _____/_____/_____

Statement of Medical Necessity and Informed Consent:

In accordance with Massachusetts General Law Chapter 111, Section 70G, and New York Civil Rights Law Section 79-1 verification of patient informed consent is required for genetic testing. Additionally, testing laboratories located in Massachusetts require a signed acknowledgment from the ordering medical practitioner. The signed acknowledgment is required to complete the genetic testing ordered if you have not previously signed a blanket Physician Attestation of Informed Consent (PAIC) at any Quest lab.

Prior to ordering genetic testing on the patient listed above, I have obtained a signed, written consent form from the patient (or their authorized representative) as required by applicable state law and/or regulations, and I will maintain all written consent forms as part of the patient file and make them available to Athena Diagnostics upon reasonable request. Many payers (including Medicare and Medicaid) have medical necessity requirements consistent with local state regulatory requirements for the test ordered. I understand I should only order those tests which are medically necessary for the diagnosis and treatment of the patient consistent with local state regulatory requirements for the test ordered. I further confirm this test is medically necessary for the diagnosis or detection of disease, illness, impairment, symptom, syndrome, or disorder and the results will be used in the medical management and treatment decisions for the patient consistent with local state regulatory requirements for the test ordered. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test(s) requested herein consistent with local state regulatory requirements for the test ordered.

Please sign, date and include your credentialed (MD, DO, NP) to document your intent to order the testing. Please note that if the information is not provided, you may be required to provide medical records and/or progress notes to support intent to order on payor request.

Medical Practitioner Signature: _____ **Date** _____/_____/_____**Medical Practitioner Credentials:** _____

Payment Option Selection and Details:

Please check the preferred payment option and complete the corresponding section.

***To be completed by patient/guardian, and signature is required.**

For Billing inquiries provide contact information.

Name: _____

Mobile Phone (includes texts) _____ Email _____

☐ **Option 1: Insurance Pay** *(Please provide a photocopy of the front and back of ALL insurance cards, including secondary)*

Name of Insured: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Insurance Company: _____ Member ID# _____ Group ID# _____

Does the patient have secondary insurance? ☐ Yes ☐ No

Insurance Company: _____ Member ID# _____ Group ID# _____

Referral/Prior authorization # (please attach referral/authorization): _____

☐ **Option 1A: Athena Alliance Program (AAP) Patient Assistance**

NOTE: AAP is not available for Advance Pay/self-paying clients.

Please see the Athena Website for further information about the AAP offering (<https://www.athenadiagnostics.com/insurance-billing/athena-alliance-program>)

To expedite consideration for AAP eligibility, please provide the number of household members (including yourself) _____ and the annual income of your household (Annual household income includes the income of tax filer (if any), their spouse or partner, and their dependents with income). \$ _____.

If you do not qualify for AAP and you do not want to have insurance billed, CHECK HERE ☐ to place order on hold to have discussion about test cost and Advance Pay. Please see the Advance Pay Section.

NOTE: Athena Diagnostics does not hold Immunology test codes.

Patient Acknowledgement

I hereby acknowledge that the above information is true and correct to the best of my knowledge. I also authorize the release of any and all financial records necessary to verify the above information. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing. The contact information above will be used to communicate with me unless I provide alternative information. For more detailed information on the AAP program or to complete and send an AAP application separately, go to www.athenadiagnostics.com. For some Medicaid and Medicare beneficiaries, payment is required prior to genetic testing. I understand that if my physician ordered genetic testing and I have Medicare, an Advanced Beneficiary Notice (ABN) is required prior to the test proceeding. I authorize Athena Diagnostics to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/ insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/ insurance carrier to directly pay Athena for the services rendered. I understand that I may be responsible for portions of this test not covered by my insurance if I do not qualify for and submit an AAP application.

☐ I am a New York Resident and I give Athena Diagnostics permission to store my sample for longer than 60 days.

***Signature of Patient/Responsible Party:** _____ **Date** _____

☐ **Option 2: Athena Advance Pay Program** **Only available for genetic testing**

Please see the Athena website for further information about the Advance Pay offering (<https://www.athenadiagnostics.com/insurance-billing/athena-advance-pay-program>)

I do not wish for this testing to be submitted for reimbursement to my health insurance plan and am electing to be treated as a self-pay patient for this testing. If I have insurance coverage, I acknowledge and agree Athena Diagnostics will not submit a claim to my insurance for this testing or provide me with information that may be needed by the health insurance plan for a claim.

By agreeing to Advance Pay, I understand that I will be receiving a 20% discount off the cost of this test. I acknowledge that if I fail to pay the amount due within 30 days of Athena receiving my sample, I will be charged the full cost of testing unless I qualify for AAP.

***Signature of Patient/Responsible Party:** _____ **Date:** _____ **Amount*:** _____

*Call Athena Diagnostics at 1.800.394.4493, option 4 for Advance Pay price. By selecting this option, I agree to pay the full Advance Pay amount within 30 Days of specimen receipt.

In test codes that have multiple phases (reflexive components), there is a chance for the patient to receive a subsequent bill if the test result meets the criteria to reflex/move to the next phase. By electing the Advance Pay Option you will still receive the 20% discount on the reflexive component of the ordered test. For questions on whether or not the ordered test code is reflexive, please call 1.800.394.4493, option 4.

A valid email address or mobile telephone number is required for Advance Pay participation. By providing an email address and/or mobile telephone number, the patient consents to receive calls, emails and/or text messages to collect payment (normal message and data rates may apply). The messages will not include test information or results. For more information, the patient may call 1.800.394.4493, option 4.

Mobile Phone: _____ Email: _____

Important: Please be sure to write in the test code(s) and test name(s) within the Test Information section on page 1.

Reflexive testing is performed at an additional charge.

The Advance Pay Option is accepted for all Molecular Genetics test codes that do not have an Immunology or STAT component. These test codes will be noted as not qualifying for Advance Pay in the Additional Information (Genes, Antibodies, Comments) Columns below.



MOLECULAR GENETICS SPECIMEN REQUIREMENTS: Specimen Type = Blood, Volume = 8 mL, Tube Type = Lavender Top.

NOTE1: Saliva is acceptable for most genetic tests. Call Athena at 1-800-394-4493 to order Saliva kits and see the Additional Information Column for exceptions.

NOTE2: The pediatric minimum is 2 mL for Neurodevelopmental Disorders & Epilepsy.

NOTE3: Copy Number Variant (CNV) is equivalent to Deletion and Duplication.

IMMUNOLOGY SPECIMEN REQUIREMENTS: Specimen Type = Serum, Volume = 2 mL, Tube Type = Serum Separator Tube.

Please Refer to the Additional Information (Genes, Antibodies, Comments) Column below for specimen requirement exceptions.

NEUROLOGY GENETIC & IMMUNOLOGY TESTING			
Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)	
Cerebrovascular Disease (Stroke): Molecular Genetics			
<input type="checkbox"/> 1175	Notch3 (CADASIL) Sequencing Test		
<input type="checkbox"/> 1149	HTRA1 (CARASIL) Sequencing Test		
<input type="checkbox"/> 1120	COL4A1 Sequencing Test (CSVD)		
<input type="checkbox"/> 1122	Complete CCM Sequencing and CNV Evaluation		
Individual CCM single gene tests: Only order single gene tests when not ordering the panel. <input type="checkbox"/> 1152 KRIT1 (CCM1) Seq. and CNV Evaluation <input type="checkbox"/> 1106 CCM2 Seq. and CNV Evaluation <input type="checkbox"/> 1179 PDCD10 (CCM3) Seq. and CNV Evaluation			
Dementia: Molecular Genetics			
<input type="checkbox"/> 109	ADmark® ApoE Genotype Analysis & Interpretation (Symptomatic for Dementia)	PSEN1, APP Seq./Dup., PSEN2	
<input type="checkbox"/> 179	ADmark® Early-Onset Alzheimer's Evaluation		
Individual ADmark® Early-Onset Alzheimer's single gene tests: Only order single gene tests when not ordering the panel. <input type="checkbox"/> 168 ADmark® APP DNA Sequencing Test and Duplication Test <input type="checkbox"/> 167 ADmark® PSEN1 DNA Sequencing Test <input type="checkbox"/> 169 ADmark® PSEN2 DNA Sequencing Test			
<input type="checkbox"/> 281	Frontotemporal Dementia (FTD) Evaluation	MAPT, GRN, C9orf72	
Individual FTD single gene tests: Only order single gene tests when not ordering the panel. <input type="checkbox"/> 209 C9orf72 (FTD) DNA Test <input type="checkbox"/> 204 GRN DNA Sequencing Test <input type="checkbox"/> 205 MAPT DNA Sequencing Test			
Dementia: Immunology			
<input type="checkbox"/> 5209	ADmark® Alzheimer's Evaluation, CSF (FDA Cleared)	Collection Instructions: Perform lumbar puncture (LP) using gravity drip collection method prior to 12 PM. Avoid the use of syringes or tubings. Do not use the first 2 mL of CSF for AD Biomarker measurement. Specimen Requirements: 1 mL (0.7 mL minimum) of CSF directly into the CSF tube 63.614.625 (Sarstedt). Transport Requirements: Ship on cold packs or frozen; Keep sample at 2-8° C during transport and storage up to the time of measurement.	
<input type="checkbox"/> 1711	Autoimmune Rapidly Progressive Dementia Evaluation with Recombx®		
Individual Autoimmune Dementia single antibody tests: Only order single autoantibody tests when not ordering the panel. <input type="checkbox"/> 1714 Recombx® Hu Autoantibody Test* <input type="checkbox"/> 1716 Recombx® MaTa Autoantibody Test* <input type="checkbox"/> 1717 Recombx® CV2 Autoantibody Test* <input type="checkbox"/> 1718 Recombx® Amphiphysin Autoantibody Test* <input type="checkbox"/> 1705 GAD65 Autoantibody Test <input type="checkbox"/> 1706 NMDA Receptor Autoantibody Test* <input type="checkbox"/> 1707 VGKC Autoantibody Test <input type="checkbox"/> 1708 LGI1 Autoantibody Test* <input type="checkbox"/> 1709 CASPR2 Autoantibody Test*			
* NOTE: Cerebrospinal Fluid (CSF) is an acceptable sample type for these tests.			

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)	
Epilepsy: Molecular Genetics			
<input type="checkbox"/> 6000	Epilepsy Advanced Sequencing and CNV Evaluation	Test 6000 contains all genes included in the sub-panels. NOTE: Only select sub-panels if 6000 is not ordered. Please see website for the list of genes in each panel.	
<input type="checkbox"/> 6018	Developmental Brain Malformations		
<input type="checkbox"/> 6023	Epilepsy with Migraine		
<input type="checkbox"/> 6010	Epileptic Encephalopathy		
<input type="checkbox"/> 6008	Generalized, Absence, Focal, Febrile and Myoclonic Epilepsies		
Epilepsy: Molecular Genetics (Continued)			
<input type="checkbox"/> 6038	Infantile Spasms	Test 6000 contains all genes included in the sub-panels. NOTE: Only select sub-panels if 6000 is not ordered.	
<input type="checkbox"/> 6019	Intellectual Disability		
<input type="checkbox"/> 6022	Neuronal Ceroid Lipofuscinosis		
<input type="checkbox"/> 6033	Syndromic Disorders	Please see website for the list of genes in each panel.	
<input type="checkbox"/> 1131	Complete Tuberous Sclerosis Sequencing and CNV Evaluation	Full Sequencing of TSC1 & TSC2	
Individual Tuberous Sclerosis single gene tests: Only order single gene tests when not ordering the panel. <input type="checkbox"/> 1236 TSC1 CNV Test <input type="checkbox"/> 1254 TSC2 CNV Test <input type="checkbox"/> 508 TSC1 Deletion Analysis (for NYS Only) <input type="checkbox"/> 524 TSC2 DNA Deletion Test (for NYS Only) <input type="checkbox"/> 1245 TSC1 Sequencing Test <input type="checkbox"/> 1255 TSC2 Sequencing Test			
<input type="checkbox"/> 523	TSC Familial DNA Seq. Mutation Evaluation Proband Accession # _____ Relationship _____		
<input type="checkbox"/> 1129	SCN1A Seq. and CNV Evaluation		
Individual SCN1A tests: <input type="checkbox"/> 1191 SCN1A CNV Test <input type="checkbox"/> 537 SCN1A Deletion Test			
<input type="checkbox"/> 1036	ARX Seq. and CNV Evaluation (Epilepsy)		
<input type="checkbox"/> 1115	CDKL5 Seq. and CNV Evaluation (Epilepsy)		
<input type="checkbox"/> 4411	SLC2A1 DNA Sequencing Test		
<input type="checkbox"/> 1003	GFAP (Alexander Disease) Seq. Test		
<input type="checkbox"/> 443	POLG DNA Seq. Test (Alpers Syndrome)		
Epilepsy: Immunology			
<input type="checkbox"/> 5120	Autoimmune Epilepsy Evaluation	GAD65, VGKC, CASPR2, LGI1, NMDA	
Individual Autoimmune Epilepsy single antibody tests: Only order single antibody tests when not ordering the panel. <input type="checkbox"/> 5103 CASPR2 Autoantibody Test (Epilepsy) (Single) <input type="checkbox"/> 5101 GAD65 Neurological Syndrome Autoantibody Test (Epilepsy) (Single) <input type="checkbox"/> 5104 LGI1 Autoantibody Test (Epilepsy) (Single) <input type="checkbox"/> 5105 NMDA Receptor Autoantibody Test (Epilepsy) (Single) <input type="checkbox"/> 5102 VGKC Autoantibody Test (Epilepsy) (Single)			

Important: Please be sure to write in the test code(s) and test name(s) within the Test Information section on page 1.

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MOLECULAR GENETICS SPECIMEN REQUIREMENTS: Specimen Type = Blood, Volume = 8 mL, Tube Type = Lavender Top.

NOTE1: Saliva is acceptable for most genetic tests. Call Athena at 1-800-394-4493 to order Saliva kits and see the Additional Information Column for exceptions.

NOTE2: The pediatric minimum is 2 mL for Neurodevelopmental Disorders & Epilepsy.

NOTE3: Copy Number Variant (CNV) is equivalent to Deletion and Duplication.

IMMUNOLOGY SPECIMEN REQUIREMENTS: Specimen Type = Serum, Volume = 2 mL, Tube Type = Serum Separator Tube.

Please Refer to the Additional Information (Genes, Antibodies, Comments) Column below for specimen requirement exceptions.

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)
Family Testing:		
<input type="checkbox"/> 185	Familial DNA Sequence Evaluation	This test detects previously identified sequence variants in at-risk family members. For Familial TSC variants, please order Code 523. Proband Accession # _____ Relationship _____
Immunology: Anti-Drug Antibody		
<input type="checkbox"/> 1181	AAV9 Antibody Test	Does not qualify for the Advance Pay Option.
Leukodystrophy: Molecular Genetics		
<input type="checkbox"/> 6106	Leukoencephalopathy with Vanishing White Matter Evaluation	EIF2B1, EIF2B2, EIF2B3, EIF2B4, EIF2B5
Individual Leukoencephalopathy with Vanishing White Matter single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 6101	EIF2B1 DNA Sequencing Test	<input type="checkbox"/> 6102 EIF2B2 DNA Sequencing Test
<input type="checkbox"/> 6103	EIF2B3 DNA Sequencing Test	<input type="checkbox"/> 6104 EIF2B4 DNA Sequencing Test
<input type="checkbox"/> 6105	EIF2B5 DNA Sequencing Test	
<input type="checkbox"/> 6108	ABCD1 DNA Sequencing Test	
<input type="checkbox"/> 6107	ARSA DNA Sequencing Test	
<input type="checkbox"/> 6109	GJC2 DNA Sequencing Test	
<input type="checkbox"/> 1175	Notch3(CADASIL) Sequencing Test	
Migraine: Molecular Genetics		
<input type="checkbox"/> 1148	Hemiplegic Migraine Sequencing Evaluation	CACNA1A, ATP1A2, SCN1A
Individual Hemiplegic Migraine single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 1101	ATP1A2 Sequencing Test	<input type="checkbox"/> 1103 CACNA1A Sequencing Test
<input type="checkbox"/> 1136	SCN1A Sequencing Test (FHM)	
Motor Neuron Diseases: Molecular Genetics		
<input type="checkbox"/> 6520	Amyotrophic Lateral Sclerosis Advanced Evaluation	Please see website for the complete list of genes.
<input type="checkbox"/> 6522	Nonprevalent Amyotrophic Lateral Sclerosis Advanced Sequencing Evaluation	
<input type="checkbox"/> 670	C9orf72 DNA Test	
<input type="checkbox"/> 620	SOD1 DNA Sequencing Test	
<input type="checkbox"/> 6630	HSP, Comprehensive Evaluation	Please see website for the complete list of genes. Test 6630 contains all genes included in the sub-panels. NOTE: Only select sub-panels if 6630 is not ordered.
<input type="checkbox"/> 6601	HSP, Common Sporadic Evaluation	SPAST, SPG7
<input type="checkbox"/> 6602	HSP, Supplemental Sporadic Evaluation	Please see website for the complete list of genes.
<input type="checkbox"/> 6610	HSP, Complete Dominant Evaluation	
<input type="checkbox"/> 6611	HSP, Common Dominant Evaluation	SPAST, ATLN, REEP1, KIF5A
<input type="checkbox"/> 6612	HSP, Supplemental Dominant Evaluation	BSCL2, HSPD1, KIAA0196, NIPA1, RTN2, SLC33A1
<input type="checkbox"/> 6620	HSP, Complete Recessive Evaluation	Please see website for the complete list of genes.
<input type="checkbox"/> 6621	HSP, Common Recessive Evaluation	SPG11, ZFYVE26, SPG7

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)
<input type="checkbox"/> 6622	HSP, Supplemental Recessive Evaluation	Please see website for the complete list of genes.
<input type="checkbox"/> 6631	HSP, X-Linked Evaluation	L1CAM, PLP1
<input type="checkbox"/> 6509	SPG4 Evaluation	SPAST
Movement Disorders: Molecular Genetics		
Individual HSP DNA Tests: Only order single gene tests when not ordering the panel.		SPG3A SPG7 SPG11 SPG15
<input type="checkbox"/> 531	Atlastin	
<input type="checkbox"/> 632	Paraplegin	
<input type="checkbox"/> 633	Spatacin	
<input type="checkbox"/> 614	ZFYVE26	
<input type="checkbox"/> 117	Kennedy's Disease (SBMA) DNA Test	
<input type="checkbox"/> 6930	Ataxia, Comprehensive Evaluation	Please see website for the complete list of genes. Test 6930 contains all genes included in the sub-panels. NOTE: Only select sub-panels if 6930 is not ordered. Cannot be performed on saliva.
<input type="checkbox"/> 6900	Ataxia, Complete Dominant Evaluation	Please see website for the complete list of genes. Cannot be performed on saliva.
<input type="checkbox"/> 6901	Ataxia, Common Repeat Expansion Evaluation	
<input type="checkbox"/> 6903	Ataxia, Supplemental Dominant Evaluation	
<input type="checkbox"/> 6910	Ataxia, Complete Recessive Evaluation	Please see website for the complete list of genes.
<input type="checkbox"/> 6911	Ataxia, Supplemental Recessive Evaluation	
<input type="checkbox"/> 6912	Oculomotor Apraxia Ataxia Advanced Sequencing Evaluation	APTX, SETX
<input type="checkbox"/> 6920	Episodic Ataxia Evaluation	CACNB4, KCNA1, SLC1A3, CACNA1A
<input type="checkbox"/> 349	Ataxia, Friedreich (FXN) Evaluation	FRDA/FXN Seq., FRDA/FXN Expansion
<input type="checkbox"/> 353	Ataxia-Telangiectasia (ATM) Evaluation	ATM Seq., ATM Dup./Del.
Individual Ataxia single gene DNA Tests: Only order single gene tests when not ordering the panel or sub-panels.		SCA8 and SCA10 test cannot be performed on saliva.
<input type="checkbox"/> 401	DRPLA	
<input type="checkbox"/> 119	FRDA/FXN Expansion	
<input type="checkbox"/> 348	FRDA/FXN Seq.	
<input type="checkbox"/> 383	POLG1 (MIRAS)	
<input type="checkbox"/> 371	SCA1 (ATXN1)	
<input type="checkbox"/> 672	SCA2 (ATXN2)	
<input type="checkbox"/> 105	SCA3 (ATXN3)	
<input type="checkbox"/> 373	SCA6 (CACNA1A)	
<input type="checkbox"/> 677	SCA7 (ATXN7)	
<input type="checkbox"/> 384	SCA8 (ATXN8OS)	
<input type="checkbox"/> 387	SCA10 (ATXN10)	
<input type="checkbox"/> 285	SCA12 (PPP2R2B)	
<input type="checkbox"/> 388	SCA17 (TBP)	
<input type="checkbox"/> 283	TTPA (AVED)	
<input type="checkbox"/> 402	Chorea Differential Evaluation (DRPLA, Huntington's Disease)	Cannot be performed on saliva.
<input type="checkbox"/> 116	Huntington Disease Repeat Expansion Test	Cannot be performed on saliva.
<input type="checkbox"/> 639	Isolated Dystonia Evaluation	DYT1, THAP1

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NOTE2: The pediatric minimum is 2 mL for Neurodevelopmental Disorders & Epilepsy.

NOTE3: Copy Number Variant (CNV) is equivalent to Deletion and Duplication.

IMMUNOLOGY SPECIMEN REQUIREMENTS: Specimen Type = Serum, Volume = 2 mL, Tube Type = Serum Separator Tube.

Please Refer to the Additional Information (Genes, Antibodies, Comments) Column below for specimen requirement exceptions.

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)
Movement Disorders: Molecular Genetics (Continued)		
Individual Isolated Dystonia single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 626	Dystonia (DYT1) DNA Test	
<input type="checkbox"/> 618	THAP1 DNA Sequencing Test	
<input type="checkbox"/> 629	Complete Dopa-Responsive Dystonia (DYT5) Evaluation	GCH1 Seq., GCH1 Del., TH Seq.
Individual Dopa-Responsive Dystonia single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 637	GCH1 DNA Sequencing Test	DYT5A
<input type="checkbox"/> 638	GCH1 Deletion Analysis	DYT5A
<input type="checkbox"/> 634	TH DNA Sequencing Test	DYT5B
<input type="checkbox"/> 624	SGCE DNA Sequencing Test	DYT11
<input type="checkbox"/> 627	SGCE Deletion Analysis	DYT11
<input type="checkbox"/> 617	PNKD (MR-1) DNA Sequencing Test	
<input type="checkbox"/> 588	Complete Parkinsonism Evaluation	LRRK2, PARK2, PINK1, PARK7, SNCA
Individual Parkinsonism single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 557	Alpha Synuclein (SNCA) DNA Seq. Test	<input type="checkbox"/> 059 Alpha Synuclein (SNCA) Dup./Del. Test
<input type="checkbox"/> 558	LRRK2 DNA Sequencing Test	<input type="checkbox"/> 559 PARK2 (Parkin) DNA Sequencing Test
<input type="checkbox"/> 040	PARK2 (Parkin) Duplication/Deletion Test	<input type="checkbox"/> 554 PARK7 (DJ1) DNA Sequencing Test
<input type="checkbox"/> 047	PARK7 (DJ1) Deletion Test	<input type="checkbox"/> 542 PINK1 DNA Sequencing Test
<input type="checkbox"/> 058	PINK1 Deletion Test	
<input type="checkbox"/> 1187	PRRT2 (Dyskinesia/IC) Seq. Test	
Multiple Sclerosis/Demyelinating Diseases: Immunology		
<input type="checkbox"/> 1287	NMO Spectrum Evaluation	AQP4, CBA reflex to MOG, CBA
<input type="checkbox"/> 1282	Aquaporin-4 (AQP4) (NMO IgG) Antibody, CBA with Reflex to Titer	Cerebrospinal Fluid (CSF) is an acceptable sample type.
<input type="checkbox"/> 1523	Myelin Oligodendrocyte Glycoprotein (MOG) Antibody, CBA with Reflex to Titer	Cerebrospinal Fluid (CSF) is an acceptable sample type.
<input type="checkbox"/> 1284	NMO Spectrum Evaluation	AQP4, ELISA reflex to MOG, CBA
<input type="checkbox"/> 193	Aquaporin-4 (AQP4) Antibody (NMO-IgG), ELISA	
<input type="checkbox"/> 112	NAbFeron® (INFB-1) Neutralizing Antibody Test	
<input type="checkbox"/> 197	TYSABRI® (Natalizumab) Antibody Test	See website for collection notes
Myasthenia Gravis: Immunology		
<input type="checkbox"/> 1521	Myasthenia Gravis Panel 2 with Reflex to MuSK Antibody	
<input type="checkbox"/> 1514	Myasthenia Gravis Panel 2	Includes AChR Binding / Blocking / Modulating Antibody
<input type="checkbox"/> 1490	MuSK and LRP4	

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)
<input type="checkbox"/> 1510	Acetylcholine Receptor Binding Antibody with Reflex to Musk Antibody	
<input type="checkbox"/> 1511	Acetylcholine Receptor Binding Antibody with Reflex to MuSK/LRP4 Antibodies	
Individual Myasthenia Gravis single antibody tests: Only order single antibody tests when not ordering the corresponding panel option(s).		
<input type="checkbox"/> 1513	Acetylcholine Receptor Binding Antibody	<input type="checkbox"/> 1483 LRP4 Autoantibody Test
<input type="checkbox"/> 1516	Acetylcholine Receptor Blocking Antibody	<input type="checkbox"/> 1481 RyR Autoantibody Test
<input type="checkbox"/> 1517	Acetylcholine Receptor Modulating Antibody	<input type="checkbox"/> 1480 Titin Autoantibody Test
<input type="checkbox"/> 482	MuSK Antibody Test	
Neurodevelopmental Disorders: Molecular Genetics		
<input type="checkbox"/> 1186	Primary Microcephaly Sequencing Evaluation	ASPM, MCPH1, WDR62
Individual Primary Microcephaly single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 1092	ASPM Sequencing Test	<input type="checkbox"/> 1153 MCPH1 Sequencing Test
<input type="checkbox"/> 1257	WDR62 Sequencing Test	
<input type="checkbox"/> 1193	SHANK3 Sequencing Test	
<input type="checkbox"/> 1192	SHANK2 Sequencing Test	
<input type="checkbox"/> 1190	PTEN Sequencing Test	
<input type="checkbox"/> 795	Joubert Syndrome Evaluation	
Individual Joubert Syndrome single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 790	AHI1 DNA Sequencing Test	<input type="checkbox"/> 794 CC2D2A DNA Sequencing Test
<input type="checkbox"/> 791	CEP290 DNA Sequencing Test	<input type="checkbox"/> 793 NPHP1 DNA Deletion Test
<input type="checkbox"/> 789	TMEM216 DNA Sequencing Test	<input type="checkbox"/> 792 TMEM67 DNA Sequencing Test
<input type="checkbox"/> 1155	MECP2 Sequencing and CNV Evaluation	
<input type="checkbox"/> 1114	CDKL5 Seq. and CNV Evaluation (Atypical Rett)	
<input type="checkbox"/> 148	Rett Syndrome (MECP2) Dup./Del. Test	
<input type="checkbox"/> 737	Smith-Lemli-Opitz Syndrome (DHCR7) DNA Sequencing Test	
<input type="checkbox"/> 1256	VPS13B (COH1) Sequencing Test	
Neurodevelopmental Disorders: Molecular Genetics (Continued)		
<input type="checkbox"/> 1038	ARX Seq. and CNV Evaluation (Intellectual Disability)	
<input type="checkbox"/> 1194	SYNGAP1 Sequencing Test	
<input type="checkbox"/> 1166	MEF2C Sequencing and CNV Evaluation	
<input type="checkbox"/> 1142	FOXP1 Sequencing and CNV Evaluation	

Important: Please be sure to write in the test code(s) and test name(s) within the Test Information section on page 1.

Reflexive testing is performed at an additional charge.

The Advance Pay Option is accepted for all Molecular Genetics test codes that do not have an Immunology or STAT component. These test codes will be noted as not qualifying for Advance Pay in the Additional Information (Genes, Antibodies, Comments) Columns below.



MOLECULAR GENETICS SPECIMEN REQUIREMENTS: Specimen Type = Blood, Volume = 8 mL, Tube Type = Lavender Top.

NOTE1: Saliva is acceptable for most genetic tests. Call Athena at 1-800-394-4493 to order Saliva kits and see the Additional Information Column for exceptions.

NOTE2: The pediatric minimum is 2 mL for Neurodevelopmental Disorders & Epilepsy.

NOTE3: Copy Number Variant (CNV) is equivalent to Deletion and Duplication.

IMMUNOLOGY SPECIMEN REQUIREMENTS: Specimen Type = Serum, Volume = 2 mL, Tube Type = Serum Separator Tube.

Please Refer to the Additional Information (Genes, Antibodies, Comments) Column below for specimen requirement exceptions.

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)
Neuromuscular Disorders: Molecular Genetics		
<input type="checkbox"/> 5501	Muscular Dystrophy Advanced Evaluation	Please see website for the complete list of genes.
<input type="checkbox"/> 5502	Congenital Muscular Dystrophy Advanced Sequencing Evaluation	
<input type="checkbox"/> 5503	Congenital Myopathy Advanced Sequencing Evaluation	
<input type="checkbox"/> 5504	Distal Myopathy Advanced Sequencing Evaluation	
<input type="checkbox"/> 5505	Myofibrillar Myopathy Advanced Sequencing Evaluation	
<input type="checkbox"/> 5506	Myotonic Syndromes Advanced Evaluation	Please see website for the complete list of genes. Cannot be performed on saliva.
<input type="checkbox"/> 5507	Periodic Paralysis Advanced Sequencing Evaluation	Please see website for the complete list of genes.
<input type="checkbox"/> 5508	Malignant Hyperthermia Advanced Sequencing Evaluation	
<input type="checkbox"/> 5511	Congenital Myasthenic Syndrome Advanced Sequencing Evaluation	
<input type="checkbox"/> 5518	Emery-Dreifuss Muscular Dystrophy Advanced Sequencing Evaluation	
<input type="checkbox"/> 5519	Limb Girdle Muscular Dystrophy Advanced Evaluation	
Individual Limb Girdle Muscular Dystrophy Tests: Only order single gene tests when not ordering the panel. <div><input type="checkbox"/> 563 Calpain 3 DNA Sequencing Test<input type="checkbox"/> 584 CAPN3 Duplication/Deletion Test<input type="checkbox"/> 566 CAV3 DNA Sequencing Test<input type="checkbox"/> 562 FKRP DNA Sequencing Test<input type="checkbox"/> 565 LMNA DNA Sequencing Test<input type="checkbox"/> 582 SGCA Duplication/Deletion Test<input type="checkbox"/> 583 SGCG Duplication/Deletion Test</div>		
<input type="checkbox"/> 5530	DMD Evaluation	
Individual DMD Evaluation single gene tests: Only order single gene tests when not ordering the panel. <div><input type="checkbox"/> 183 DMD DNA Sequencing Test<input type="checkbox"/> 5531 DMD Duplication/Deletion Test</div>		
<input type="checkbox"/> 207	Early-Onset Myotonia Evaluation	DM1, CLCN1, SCN4A Cannot be performed on saliva.
Individual Early-Onset Myotonia single gene tests: Only order single gene tests when not ordering the panel. <div><input type="checkbox"/> 128 CLCN1 DNA Sequencing Test<input type="checkbox"/> 146 SCN4A (Myotonia) DNA Sequencing Test</div>		
<input type="checkbox"/> 108	DMPK DNA Test (DM1)	Cannot be performed on saliva.
<input type="checkbox"/> 110	CNBP DNA Test (DM2) (DM2 testing is not recommended for patients with early onset myotonic dystrophy)	Cannot be performed on saliva.
<input type="checkbox"/> 585	CAPN3 Evaluation	Includes CAPN3 Seq., CAPN3 Del.
<input type="checkbox"/> 571	Dysferlin DNA Sequencing Test	
<input type="checkbox"/> 300	OPMD Repeat Expansion Test	Cannot be performed on saliva.
<input type="checkbox"/> 490	OPA1 DNA Sequencing Test (optic atrophy)	Related to optic atrophy.
Neuro-Oncology: Molecular Genetics		
<input type="checkbox"/> 648	Neurofibromatosis Type 1 (NF1) Evaluation	NF1 Sequencing, NF1 Deletion

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)
Individual NF1 single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 647	Neurofibromatosis Type 1 Deletion Test	
<input type="checkbox"/> 646	Neurofibromatosis Type 1 DNA Sequencing Test	
<input type="checkbox"/> 645	Neurofibromatosis Type 2 (NF2) Evaluation	NF2 Seq., NF2 Dup./Del.
Individual NF2 single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 635	Neurofibromatosis Type 2 DNA Sequencing Test	
<input type="checkbox"/> 644	Neurofibromatosis Type 2 Duplication/Deletion Test	
Paraneoplastic & Other Antibody Disorders of the CNS: Immunology		
<input type="checkbox"/> 4711	Paraneoplastic Neurological Syndromes Evaluation with Recombx®, Initial Assessment	Cerebrospinal Fluid (CSF) is an acceptable sample type. Amphiphysin, CV2, Hu, MaTa, Ri, Yo
<input type="checkbox"/> 4620	NeoComplete Paraneoplastic Evaluation with Recombx®	
<input type="checkbox"/> 4640	Paraneoplastic Autoantibody Evaluation with Recombx®, CSF *	* NOTE: Cerebrospinal Fluid (CSF) is an acceptable sample type
<input type="checkbox"/> 4724	NeoCerebellar Degeneration Paraneoplastic Profile with Recombx®	Please see website for the complete list of antibodies.
<input type="checkbox"/> 4722	NeoEncephalitis Paraneoplastic Evaluation with Recombx®	
<input type="checkbox"/> 4725	NeoSensory Neuropathy Paraneoplastic Profile with Recombx®	Cerebrospinal Fluid (CSF) is an acceptable sample type. Amphiphysin, CV2, Hu
<input type="checkbox"/> 4727	Neuromyotonia Evaluation	CASPR2, VGKC
Individual antibody Tests: Only order single antibody tests when not ordering the corresponding panel option(s).		
<input type="checkbox"/> 419	NMDA Receptor Autoantibody Test*	<input type="checkbox"/> 4681 Recombx® CV2 Autoantibody Test *
<input type="checkbox"/> 422	GAD65 Neurological Syndrome Antibody Test	<input type="checkbox"/> 4682 Recombx® Hu Autoantibody Test *
<input type="checkbox"/> 428	Ganglionic AChR Antibody Test	<input type="checkbox"/> 4683 Recombx® MaTa Autoantibody Test *
<input type="checkbox"/> 449	LGI1 Antibody Test*	<input type="checkbox"/> 4684 Recombx® CAR (Anti-Recoverin) Autoantibody Test *
<input type="checkbox"/> 475	VGCC Type P/Q Autoantibody Test (LEMS)	<input type="checkbox"/> 4685 Recombx® Ri Autoantibody Test *
<input type="checkbox"/> 485	VGKC Antibody Test	<input type="checkbox"/> 4686 Recombx® Yo Autoantibody Test *
<input type="checkbox"/> 499	CASPR2 Antibody Test*	<input type="checkbox"/> 4689 Recombx® Zic4 Autoantibody Test *
<input type="checkbox"/> 4674	Recombx® Amphiphysin Autoantibody Test *	
* NOTE: Cerebrospinal Fluid (CSF) is an acceptable sample type for these tests.		
Peripheral Neuropathy (Hereditary): Molecular Genetics		
<input type="checkbox"/> 4001	CMT Advanced Evaluation Comprehensive (Reflexive)	Testing is performed in this order: 1. PMP22 Dup./Del. If negative: 2. Cx32, PMP22, MFN2, MPZ, EGR2, LITAF, PRX, GDAP1, RAB7, GARS, NFL, HSPB1, LMNA, FIG4, SH3TC2, DNM2, YARS, FGD4, NDRG1, TRPV4, HSPB8, MTMR2, SBF2 DNA Seq.
<input type="checkbox"/> 4002	CMT Advanced Evaluation – Dominant, Demyelinating (Reflexive)	Testing is performed in this order: 1. PMP22 Dup./Del. If negative: 2. MPZ, PMP22 Seq., EGR2, LITAF, DNM2, YARS DNA Seq.

Important: Please be sure to write in the test code(s) and test name(s) within the Test Information section on page 1.

Reflexive testing is performed at an additional charge.

The Advance Pay Option is accepted for all Molecular Genetics test codes that do not have an Immunology or STAT component. These test codes will be noted as not qualifying for Advance Pay in the Additional Information (Genes, Antibodies, Comments) Columns below.



MOLECULAR GENETICS SPECIMEN REQUIREMENTS: Specimen Type = Blood, Volume = 8 mL, Tube Type = Lavender Top.

NOTE1: Saliva is acceptable for most genetic tests. Call Athena at 1-800-394-4493 to order Saliva kits and see the Additional Information Column for exceptions.

NOTE2: The pediatric minimum is 2 mL for Neurodevelopmental Disorders & Epilepsy.

NOTE3: Copy Number Variant (CNV) is equivalent to Deletion and Duplication.

IMMUNOLOGY SPECIMEN REQUIREMENTS: Specimen Type = Serum, Volume = 2 mL, Tube Type = Serum Separator Tube.

Please Refer to the Additional Information (Genes, Antibodies, Comments) Column below for specimen requirement exceptions.

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)
<input type="checkbox"/> 4003	CMT Advanced Evaluation – Dominant, Axonal	Please see website for the complete list of genes.
<input type="checkbox"/> 4004	CMT Advanced Evaluation – Recessive, Demyelinating	
<input type="checkbox"/> 4005	CMT Advanced Evaluation – Dominant (Reflexive)	Testing is performed in this order: 1. PMP22 Dup./Del. If negative: 2. MFN2, MPZ, PMP22 Seq., EGR2, LITAF, RAB7, GARS, NFL, HSPB1, DNM2, YARS, TRPV4, HSPB8 DNA Seq.
<input type="checkbox"/> 4006	CMT Advanced Evaluation – Recessive	Please see website for the complete list of genes.
<input type="checkbox"/> 4007	CMT Advanced Evaluation – Demyelinating (Reflexive)	Testing is performed in this order: 1. PMP22 Dup./Del. If negative: 2. Cx32, MPZ, PMP22 Seq., EGR2, LITAF, PRX, GDAP1, DNM2, YARS, SH3TC2, MTMR2, NDRG1, FGD4, FIG4, SBF2 DNA Seq
<input type="checkbox"/> 4008	CMT Advanced Evaluation – Axonal	Please see website for the complete list of genes.
<input type="checkbox"/> 4010	CMT Advanced Evaluation – Initial Genetic Assessment	
<input type="checkbox"/> 4011	CMT Advanced Evaluation – Nonprevalent Axonal	
<input type="checkbox"/> 4012	CMT Advanced Evaluation – Nonprevalent Demyelinating	
<input type="checkbox"/> 4013	CMT Advanced Evaluation – Nonprevalent	
Individual CMT single gene tests: Only order single gene tests when not ordering the panel or sub-panels.		
<input type="checkbox"/> 143 CX32 Seq./Del. (CMTX)	<input type="checkbox"/> 253 DNM2	<input type="checkbox"/> 248 EGR2
<input type="checkbox"/> 208 FGD4 (CMT2D)	<input type="checkbox"/> 225 FIG4 (CMT4J)	<input type="checkbox"/> 228 GARS
<input type="checkbox"/> 221 GDAP1 (CMT2K, 4A)	<input type="checkbox"/> 229 HSPB1 (CMT2F)	<input type="checkbox"/> 463 HSPB8
<input type="checkbox"/> 222 LITAF/SIMPLE (CMT1C)	<input type="checkbox"/> 226 LMNA (CMT2B1, 4C1)	<input type="checkbox"/> 223 MFN2
<input type="checkbox"/> 134 MPZ (CMT1B, 2I, 2J)	<input type="checkbox"/> 354 MTMR2	<input type="checkbox"/> 394 NDRG1
<input type="checkbox"/> 249 NFL (CMT2E, 1F)	<input type="checkbox"/> 131 PMP22 Dup./Del. (CMT1A)	<input type="checkbox"/> 247 PMP22 Seq.
<input type="checkbox"/> 239 PRX (CMT4F)	<input type="checkbox"/> 227 RAB7A (CMT2B)	<input type="checkbox"/> 164 SBF2
<input type="checkbox"/> 224 SH3TC2 (CMT4C)	<input type="checkbox"/> 144 TRPV4	
<input type="checkbox"/> 235 TTR DNA Sequencing Test	<input type="checkbox"/> 468 YARS	
Peripheral Neuropathy (Hereditary): Molecular Genetics (Continued)		
<input type="checkbox"/> 691	Early-Onset HSAN Evaluation	NTRK1 and WNK1
<input type="checkbox"/> 243	Complete HNPP Evaluation	PMP22 Sequencing, PMP22 Dup./Del.
<input type="checkbox"/> 245	Congenital Hypomyelination Evaluation	MPZ, EGR2
<input type="checkbox"/> 296	Entrapment Neuropathy Evaluation	PMP22 Seq., PMP22 Dup./Del., TTR
Peripheral Neuropathy (Hereditary Sensory Autonomic Neuropathy): Molecular Genetics		
Individual Early-Onset HSAN single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 659	NTRK1 (HSAN IV) DNA Sequencing Test	
<input type="checkbox"/> 553	WNK1 (HSAN II) DNA Sequencing Test	
<input type="checkbox"/> 698	Late-Onset HSAN Evaluation	SPTLC1 and SPTLC2

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)
Individual Late-Onset HSAN single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 551	SPTLC1 (HSAN I) DNA Sequencing Test	
<input type="checkbox"/> 552	SPTLC2 (HSAN I) DNA Sequencing Test	
<input type="checkbox"/> 660	ATL1 (HSAN I) DNA Sequencing Test	
<input type="checkbox"/> 719	SEPT9 (HNA) DNA Sequencing Test	
Peripheral Neuropathy (Autoimmune): Immunology		
<input type="checkbox"/> 3100	SensoriMotor Neuropathy Profile with Recombx® - Complete	GM1 Quattro®, MAG 'Dual Antigen'®, Hu, GALOPTM, Sulfatide
<input type="checkbox"/> 3148	Sensory Neuropathy Profile with Recombx®	(MAG 'Dual Antigen'®, Hu, GALOPTM, Sulfatide)
<input type="checkbox"/> 3163	Motor Neuropathy Profile - Complete	GM1 Quattro®, MAG 'Dual Antigen'®
<input type="checkbox"/> 289	Multifocal Motor Neuropathy Evaluation	Requires both Serum and whole blood. GM1 Quattro®, PMP22 Dup./Del.
<input type="checkbox"/> 3155	Co-GM1 Quattro® Autoantibody Test	(Asialo, GD1a, GD1b and GM1)
Individual Peripheral Neuropathy antibody tests: Only order the single antibody tests when not ordering the corresponding panel option(s).		
<input type="checkbox"/> 3127	MAG 'Dual Antigen'® Autoantibody Test	<input type="checkbox"/> 272 Asialo Autoantibody Test
<input type="checkbox"/> 261	GALOP™ Autoantibody Test	<input type="checkbox"/> 273 GD1b Autoantibody Test
<input type="checkbox"/> 210	Sulfatide Autoantibody Test	<input type="checkbox"/> 271 GM1 Autoantibody Test
<input type="checkbox"/> 160	GQ1b Autoantibody Test	<input type="checkbox"/> 4682 Recombx® Hu Autoantibody Test *
<input type="checkbox"/> 278	GD1a Autoantibody Test	
* NOTE: Cerebrospinal Fluid (CSF) is an acceptable sample type for these tests.		
Spinal Muscular Atrophy (SMA): Molecular Genetics		
<input type="checkbox"/> 5056	SMA Carrier Screen (New York)	Does not qualify for the Advance Pay Option. Test Codes are for New York State Clients ordering SMA testing.
<input type="checkbox"/> 5026	SMA Diagnostic (New York)	4 mL (2 mL minimum) whole blood collected in an EDTA (lavender-top) tube.
<input type="checkbox"/> 5070	SMA Plus (New York)	Pediatric (0-3 years): 2 mL (1 mL minimum).
<input type="checkbox"/> 214	SMA Plus (Reflexive)	Does not qualify for the Advance Pay Option. Test 214 includes 111 with reflex to 211.
<input type="checkbox"/> 111	Spinal Muscular Atrophy-Diagnostic	
<input type="checkbox"/> 444	Spinal Muscular Atrophy-Carrier	
<input type="checkbox"/> 211	Spinal Muscular Atrophy - SMN1 DNA Sequencing Test	
<input type="checkbox"/> 6521	Atypical SMA Advanced Sequencing Evaluation	

Important: Please be sure to write in the test code(s) and test name(s) within the Test Information section on page 1.

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MOLECULAR GENETICS SPECIMEN REQUIREMENTS: Specimen Type = Blood, Volume = 8 mL, Tube Type = Lavender Top.

NOTE1: Saliva is acceptable for most genetic tests. Call Athena at 1-800-394-4493 to order Saliva kits and see the Additional Information Column for exceptions.

NOTE2: The pediatric minimum is 2 mL for Neurodevelopmental Disorders & Epilepsy.

NOTE3: Copy Number Variant (CNV) is equivalent to Deletion and Duplication.

IMMUNOLOGY SPECIMEN REQUIREMENTS: Specimen Type = Serum, Volume = 2 mL, Tube Type = Serum Separator Tube.

Please Refer to the Additional Information (Genes, Antibodies, Comments) Column below for specimen requirement exceptions.

RENAL GENETIC TESTING			
Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)	
Alport Syndrome: Molecular Genetics			
<input type="checkbox"/> 759	Complete Alport Syndrome Evaluation	COL4A3,4,5 DNA Sequencing; COL4A5 Deletion Test	
Individual Alport Syndrome single gene tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 757	COL4A3 DNA Sequencing Test	<input type="checkbox"/> 758	COL4A4 DNA Sequencing Test
<input type="checkbox"/> 756	COL4A5 Deletion Analysis	<input type="checkbox"/> 755	COL4A5 Sequencing and Deletion Analysis
Amyloidosis: Molecular Genetics			
<input type="checkbox"/> 235	TTR DNA Sequencing Test		
Bardet-Biedl Syndrome: Molecular Genetics			
<input type="checkbox"/> 887	Bardet-Biedl Syndrome Evaluation	BBS1, BBS2, BBS10	
Individual Bardet-Biedl Syndrome single gene tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 871	BBS1 (BBS) DNA Sequencing Test	<input type="checkbox"/> 872	BBS2 (BBS) DNA Sequencing Test
<input type="checkbox"/> 886	BBS10 (BBS) DNA Sequencing Test		
Family Testing:			
<input type="checkbox"/> 185	Familial DNA Sequence Evaluation	This test detects previously identified sequence variants in at-risk family members. For Familial PKD1 and PKD2 variants, please order Code 728.	
Proband Accession # _____			
Relationship _____			
Hereditary Renal Tubular Disorders: Molecular Genetics			
<input type="checkbox"/> 767	Hereditary Renal Tubular Disorders Evaluation	SLC12A1, KCNJ1, CLCNKB, BSND, SLC12A3	
Individual Hereditary Renal Tubular Disorder single gene tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 765	BSND DNA Sequencing Test	<input type="checkbox"/> 764	CLCNKB DNA Sequencing Test
<input type="checkbox"/> 763	KCNJ1 DNA Sequencing Test	<input type="checkbox"/> 762	SLC12A1 DNA Sequencing Test
<input type="checkbox"/> 766	SLC12A3 DNA Sequencing Test		
<input type="checkbox"/> 825	CASR DNA Sequencing Test		
Monogenic Hypertension: Molecular Genetics			
<input type="checkbox"/> 749	Monogenic Hypertension Evaluation	SCNN1B, SCNN1G, CYP11B1, HSD11B2	
<input type="checkbox"/> 747	Liddle's Syndrome Evaluation	SCNN1B, SCNN1G	
<input type="checkbox"/> 748	Pseudohypoaldosteronism Type 1 Evaluation	SCNN1A, SCNN1B, SCNN1G	
Individual Monogenic Hypertension single gene tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 779	CYP11B1/CYP11B2 Chimeric Gene Fusion Test		
<input type="checkbox"/> 774	CYP11B1 DNA Sequencing Test	<input type="checkbox"/> 775	HSD11B2 DNA Sequencing Test
<input type="checkbox"/> 772	SCNN1A DNA Sequencing Test	<input type="checkbox"/> 745	SCNN1B DNA Sequencing Test
<input type="checkbox"/> 746	SCNN1G DNA Sequencing Test		
Nephrogenic Diabetes Insipidus: Molecular Genetics			
<input type="checkbox"/> 854	Nephrogenic Diabetes Insipidus Evaluation	AVPR2, AQP2	
Individual Nephrogenic Diabetes Insipidus single gene tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 852	AQP2 DNA Sequencing Test	<input type="checkbox"/> 851	AVPR2 DNA Sequencing Test
Nephrotic Syndrome: Molecular Genetics			
<input type="checkbox"/> 722	Early Onset Nephrotic Syndrome Evaluation	PLCE1, LAMB2, WT1, NPHS1, NPHS2	
Individual Early Onset Nephrotic Syndrome tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 711	ACTN4 DNA Sequencing Test	<input type="checkbox"/> 712	TRPC6 DNA Sequencing Test
<input type="checkbox"/> 718	PLCE1 DNA Sequencing Test	<input type="checkbox"/> 713	WT1 DNA Sequencing Test
<input type="checkbox"/> 714	LAMB2 DNA Sequencing Test	<input type="checkbox"/> 710	NPHS2 DNA Sequencing Test
<input type="checkbox"/> 730	NPHS1 DNA Sequencing Test		

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)	
Nephrotic Syndrome: Molecular Genetics (Continued)			
<input type="checkbox"/> 717	Focal and Segmental Glomerulosclerosis (FSGS) Evaluation	INF2, ACTN4, TRPC6, NPHS2	
Individual FSGS single gene tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 716	INF2 DNA Sequencing Test	<input type="checkbox"/> 710	NPHS2 DNA Sequencing Test
Polycystic Kidney Disease: Molecular Genetics			
<input type="checkbox"/> 728	PKDx® Familial Mutation Evaluation	Does not qualify for the Advance Pay Option. PKD1 and PKD2 Variants	
Proband Accession # _____			
Relationship _____			
<input type="checkbox"/> 8100	Complete PKDx Evaluation	Does not qualify for the Advance Pay Option.	
Individual PKDx single gene tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 8105	PKD1 Deletion Test	Does not qualify for the Advance Pay Option.	
<input type="checkbox"/> 8101	PKD1 DNA Sequencing and Deletion Evaluation		
<input type="checkbox"/> 8103	PKD1 DNA Sequencing Test		
<input type="checkbox"/> 8106	PKD2 Deletion Test		
<input type="checkbox"/> 8102	PKD2 DNA Sequencing and Deletion Evaluation		
<input type="checkbox"/> 8104	PKD2 DNA Sequencing Test		
Other Cystic Diseases: Molecular Genetics			
<input type="checkbox"/> 1131	Complete Tuberous Sclerosis Sequencing and CNV Evaluation	TSC1 & TSC2	
Individual Tuberous Sclerosis single gene tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 1236	TSC1 CNV Test	<input type="checkbox"/> 1254	TSC2 CNV Test
<input type="checkbox"/> 508	TSC1 Deletion Analysis (for NYS Only)	<input type="checkbox"/> 524	TSC2 DNA Deletion Test (for NYS Only)
<input type="checkbox"/> 1245	TSC1 Sequencing Test	<input type="checkbox"/> 1255	TSC2 Sequencing Test
Other Cystic Diseases: Molecular Genetics (Continued)			
<input type="checkbox"/> 523	TSC Familial Mutation Evaluation		
Proband Accession # _____			
Relationship _____			
<input type="checkbox"/> 770	Hereditary Interstitial Kidney Disease (UMOD) DNA Sequencing Test		
Renal Cancer: Molecular Genetics			
<input type="checkbox"/> 889	Pheochromocytoma Evaluation	RET, VHL, SDHB	
Individual Pheochromocytoma single gene tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 813	MEN2 (RET) DNA Sequencing Test	<input type="checkbox"/> 888	SDHB DNA Sequencing Test
<input type="checkbox"/> 858	von Hippel-Lindau Syndrome (VHL) DNA Sequencing Test		
<input type="checkbox"/> 818	MEN1 DNA Sequencing Test		
Renal Cysts and Diabetes: Molecular Genetics			
<input type="checkbox"/> 776	HNF1B DNA Sequencing and Deletion Evaluation (RCAD)		
Rickets: Molecular Genetics			
<input type="checkbox"/> 857	Hypophosphatemic Rickets Evaluation	PHEX, FGF23	
Individual Hypophosphatemic Rickets single gene tests: Only order single gene tests when not ordering the panel.			
<input type="checkbox"/> 856	FGF23 (Hypophosphatemic Rickets) DNA Sequencing Test		
<input type="checkbox"/> 855	PHEX (Hypophosphatemic Rickets) DNA Sequencing Test		

Important: Please be sure to write in the test code(s) and test name(s) within the Test Information section on page 1.

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MOLECULAR GENETICS SPECIMEN REQUIREMENTS: Specimen Type = Blood, Volume = 8 mL, Tube Type = Lavender Top.

NOTE1: Saliva is acceptable for most genetic tests. Call Athena at 1-800-394-4493 to order Saliva kits and see the Additional Information Column for exceptions.

NOTE2: The pediatric minimum is 2 mL for Neurodevelopmental Disorders & Epilepsy.

NOTE3: Copy Number Variant (CNV) is equivalent to Deletion and Duplication.

IMMUNOLOGY SPECIMEN REQUIREMENTS: Specimen Type = Serum, Volume = 2 mL, Tube Type = Serum Separator Tube.

Please Refer to the Additional Information (Genes, Antibodies, Comments) Column below for specimen requirement exceptions.

ENDOCRINE GENETIC TESTING					
Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)	Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)
Adrenal Disorders: Molecular Genetics					
<input type="checkbox"/> 816	Primary Adrenal Insufficiency Evaluation	ABCD1, NR0B1, AIRE	<input type="checkbox"/> 8800	Monogenic Diabetes (MODY) Four-Genes Evaluation	HNF1A (TCF1), GCK, HNF4A, HNF1B (TCF2)
Individual Primary Adrenal Insufficiency single gene tests: Only order single gene tests when not ordering the panel.			<input type="checkbox"/> 8801	Monogenic Diabetes (MODY) Three-Genes Evaluation	HNF1A (TCF1), GCK, HNF1B (TCF2)
<input type="checkbox"/> 815	ABCD1 (Adrenoleukodystrophy) DNA Sequencing Test		<input type="checkbox"/> 8802	Monogenic Diabetes (MODY) Two-Genes Evaluation	HNF1A (TCF1), GCK
<input type="checkbox"/> 812	Autoimmune Polyglandular Syndrome (AIRE) Evaluation		<input type="checkbox"/> 803	GCK (MODY2) DNA Sequencing and Deletion Test	
<input type="checkbox"/> 814	NR0B1 (Adrenal Hypoplasia Congenita) DNA Sequencing Test		<input type="checkbox"/> 802	HNF4A (MODY1) DNA Sequencing and Deletion Test	
<input type="checkbox"/> 879	Congenital Adrenal Hyperplasia (CAH) Evaluation	Includes CYP21A2 sequencing and deletion, CYP11B1 sequencing	<input type="checkbox"/> 834	IPF1 (MODY4) DNA Sequencing Test	
Individual CAH single gene tests: Only order single gene tests when not ordering the panel.			<input type="checkbox"/> 804	TCF1 (MODY3) DNA Sequencing and Deletion Test	HNF1A (TCF1)
<input type="checkbox"/> 875	CYP11B1 (CAH) DNA Sequencing Test	Required for tests 879, 880, 875: Indication for Study (check one or more below): <input type="checkbox"/> Family history of CAH <input type="checkbox"/> Virilization (ambiguous genitalia) <input type="checkbox"/> Salt Wasting <input type="checkbox"/> Parent/sibling of CAH patient <input type="checkbox"/> 17-hydroxyprogesterone (17-OHP) elevated concentration in serum <input type="checkbox"/> Other _____	Diabetes: Molecular Genetics (Continued)		
<input type="checkbox"/> 880	CYP21A2 (CAH) Evaluation		<input type="checkbox"/> 805	TCF2 (MODY5) DNA Sequencing and Deletion Test	HNF1B (TCF2)
<input type="checkbox"/> 1180	CYP21A2 Deletion Only Test		<input type="checkbox"/> 837	CEL (MODY8) Mutation Analysis	
<input type="checkbox"/> 877	CYP17A1 DNA Sequencing Test		<input type="checkbox"/> 882	Neonatal Diabetes Mellitus Evaluation	IPF1, GCK, KCNJ11, INS, ABCC8
<input type="checkbox"/> 881	Endocrine Hypertension (HSD11B2) Evaluation		Individual Neonatal Diabetes Mellitus single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 878	HSD3B2 DNA Sequencing Test		<input type="checkbox"/> 876	ABCC8 (NDM) DNA Sequencing Test	<input type="checkbox"/> 842 GCK (NDM) DNA Sequencing Test
<input type="checkbox"/> 874	Lipoid CAH (STAR) DNA Sequencing Test		<input type="checkbox"/> 853	INS (NDM) DNA Sequencing Test	<input type="checkbox"/> 841 IPF1 (NDM) DNA Sequencing Test
Bone Diseases: Molecular Genetics			<input type="checkbox"/> 843	KCNJ11 (NDM) DNA Sequencing Test	
<input type="checkbox"/> 860	Osteogenesis Imperfecta Evaluation	COL1A1, COL1A2	Nephrogenic Diabetes: Molecular Genetics		
Individual Osteogenesis Imperfecta single gene tests: Only order single gene tests when not ordering the panel.			<input type="checkbox"/> 854	Nephrogenic Diabetes Insipidus Evaluation	AVPR2, AQP2
<input type="checkbox"/> 861	COL1A1 (OI) DNA Sequencing Test	<input type="checkbox"/> 862 COL1A2 (OI) DNA Sequencing Test	Individual Nephrogenic Diabetes Mellitus single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 857	Hypophosphatemic Rickets Evaluation	PHEX, FGF23	<input type="checkbox"/> 852	AQP2 (Nephrogenic Diabetes Insipidus) DNA Sequencing Test	
Individual Hypophosphatemic Rickets single gene tests: Only order single gene tests when not ordering the panel.			<input type="checkbox"/> 851	Nephrogenic Diabetes Insipidus (AVPR2) DNA Sequencing Test	
<input type="checkbox"/> 856	FGF23 (Hypophosphatemic Rickets) DNA Sequencing Test		Familial Cancer Syndromes: Molecular Genetics		
<input type="checkbox"/> 855	PHEX (Hypophosphatemic Rickets) DNA Sequencing Test		<input type="checkbox"/> 818	MEN1 DNA Sequencing Test	
<input type="checkbox"/> 811	LRP5 (OPPG) DNA Sequencing Test		<input type="checkbox"/> 889	Pheochromocytoma Evaluation	RET, VHL, SDHB
<input type="checkbox"/> 821	LRP5 Idiopathic Osteoporosis (IOP) DNA Sequencing Test		Individual Pheochromocytoma single gene tests: Only order single gene tests when not ordering the panel.		
Congenital Hyperinsulinism: Molecular Genetics			<input type="checkbox"/> 813	MEN2 (RET) DNA Sequencing Test	<input type="checkbox"/> 888 SDHB DNA Sequencing Test
<input type="checkbox"/> 819	Congenital Hyperinsulinism Evaluation	Does not qualify for the Advance Pay Option. GLUD1, GCK, KCNJ11, ABCC8 Indication for Study (check one or more below): <input type="checkbox"/> Diazoxide Responsive <input type="checkbox"/> Diazoxide Non-Responsive <input type="checkbox"/> Hypoglycemic <input type="checkbox"/> Large for Gestational Age (LGA) <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> 858	von Hippel-Lindau Syndrome (VHL) DNA Sequencing Test	
Individual Congenital Hyperinsulinism single gene tests: Only order single gene tests when not ordering the panel.			Familial Hypocalciuric Hypercalcemia: Molecular Genetics		
Single gene tests for the CH Panel, do not qualify for the Advance Pay Option.			<input type="checkbox"/> 829	Familial Hypocalciuric Hypercalcemia (CASR) DNA Sequencing Test	
<input type="checkbox"/> 822	GLUD1 (CHI) DNA Sequencing Test	<input type="checkbox"/> 823 GCK (CHI) DNA Sequencing Test	Family Testing		
<input type="checkbox"/> 826	KCNJ11 (CHI) DNA Sequencing Test	<input type="checkbox"/> 827 ABCC8 (CHI) DNA Sequencing Test	<input type="checkbox"/> 185	Familial DNA Sequence Evaluation	This test detects previously identified sequence variants in at-risk family members.
<input type="checkbox"/> 42	CH Parental Testing – To augment child/proband diagnosis	Does not qualify for the Advance Pay Option. For expedited diagnosis of proband, send parental testing samples as soon as possible and provide information below. <input type="checkbox"/> Mother <input type="checkbox"/> Father Proband Name/Accession # _____	Proband Accession # _____		
Diabetes: Molecular Genetics			Relationship _____		
<input type="checkbox"/> 885	Monogenic Diabetes (MODY) Five-Genes Evaluation	HNF1A (TCF1), GCK, HNF4A, HNF1B (TCF2), IPF1	Noonan Syndrome: Molecular Genetics		
			<input type="checkbox"/> 846	Noonan Syndrome (PTPN11) DNA Sequencing Test	
			<input type="checkbox"/> 658	KRAS/RAF1/SOS1 DNA Sequencing Evaluation	SOS1, RAF1, KRAS
			Individual KRAS/RAF1/SOS1 single gene tests: Only order single gene tests when not ordering the panel.		
			<input type="checkbox"/> 664	KRAS DNA Sequencing Test	<input type="checkbox"/> 663 RAF1 DNA Sequencing Test
			<input type="checkbox"/> 662	SOS1 DNA Sequencing Test	
			Obesity: Molecular Genetics		
			<input type="checkbox"/> 884	Early Onset Obesity Evaluation	LEPR, MC4R
			Individual Early Onset Obesity single gene tests: Only order single gene tests when not ordering the panel.		
			<input type="checkbox"/> 640	Early Onset Obesity (MC4R) DNA Sequencing Test	
			<input type="checkbox"/> 883	Early Onset Obesity (LEPR) DNA Sequencing Test	
			<input type="checkbox"/> 887	Bardet-Biedl Syndrome Evaluation	BBS1, BBS2, BBS10

Important: Please be sure to write in the test code(s) and test name(s) within the Test Information section on page 1.

Reflexive testing is performed at an additional charge.

The Advance Pay Option is accepted for all Molecular Genetics test codes that do not have an Immunology or STAT component. These test codes will be noted as not qualifying for Advance Pay in the Additional Information (Genes, Antibodies, Comments) Columns below.



MOLECULAR GENETICS SPECIMEN REQUIREMENTS: Specimen Type = Blood, Volume = 8 mL, Tube Type = Lavender Top.

NOTE1: Saliva is acceptable for most genetic tests. Call Athena at 1-800-394-4493 to order Saliva kits and see the Additional Information Column for exceptions.

NOTE2: The pediatric minimum is 2 mL for Neurodevelopmental Disorders & Epilepsy.

NOTE3: Copy Number Variant (CNV) is equivalent to Deletion and Duplication.

IMMUNOLOGY SPECIMEN REQUIREMENTS: Specimen Type = Serum, Volume = 2 mL, Tube Type = Serum Separator Tube.

Please Refer to the Additional Information (Genes, Antibodies, Comments) Column below for specimen requirement exceptions.

Test Code	Test Name	Additional Information (Genes, Antibodies, Comments)
Individual Bardet-Biedl Syndrome single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 871	BBS1 (BBS) DNA Sequencing Test	<input type="checkbox"/> 872 BBS2 (BBS) DNA Sequencing Test
<input type="checkbox"/> 886	BBS10 (BBS) DNA Sequencing Test	
Reproductive Disorders: Molecular Genetics		
<input type="checkbox"/> 679	Complete Kallmann/IHH Evaluation	
Individual Kallmann/IHH single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 461	CHD7 DNA Sequencing Test	<input type="checkbox"/> 195 FGF8 DNA Sequencing Test
<input type="checkbox"/> 196	FGFR1 DNA Sequencing Test	<input type="checkbox"/> 343 GnRH1 DNA Sequencing Test
<input type="checkbox"/> 279	GnRHR DNA Sequencing Test	<input type="checkbox"/> 173 KAL1 DNA Sequencing Test
<input type="checkbox"/> 364	KISS1R DNA Sequencing Test	<input type="checkbox"/> 175 PROK2 DNA Sequencing Test
<input type="checkbox"/> 180	PROKR2 DNA Sequencing Test	<input type="checkbox"/> 358 TACR3 DNA Sequencing Test
<input type="checkbox"/> 462	Anosmic Kallmann/IHH Evaluation	Please see website for the complete list of genes.
<input type="checkbox"/> 667	Normosmic Kallmann/IHH Evaluation	
<input type="checkbox"/> 817	Male Precocious Puberty (LHCGR) DNA Sequencing Test	
Short Stature: Molecular Genetics		
<input type="checkbox"/> 865	Combined Pituitary Hormone Deficiency Evaluation	PROP1, POU1F1
Individual Pituitary Hormone Deficiency single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 864	POU1F1 (CPHD) DNA Sequencing Test	
<input type="checkbox"/> 863	PROP1 (CPHD) DNA Sequencing Test	
<input type="checkbox"/> 848	Growth Hormone Deficiency Evaluation	GH1 and GHRHR Seq.; SHOX Seq. and Del.
Individual Growth Hormone Deficiency single gene tests: Only order single gene tests when not ordering the panel.		
<input type="checkbox"/> 866	GH1 (GHD) DNA Sequencing Test	<input type="checkbox"/> 868 GHRHR (GHD) DNA Sequencing Test
<input type="checkbox"/> 847	SHOX (GHD) DNA Sequencing and Deletion Test	
<input type="checkbox"/> 867	GHR DNA Sequencing Test	

NOTES

