Athena Diagnostics NewbornDx™ Advanced Sequencing Evaluation Test Requisition (July 2019)

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

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Fields in red indicate required information

Complete this requisition for direct billing to hospitals, laboratories or clinics.

Name _____

Phone _____

Fax _____

Email _____

Test Options **Test code**

NewbornDx™ Advanced Sequencing Evaluation

☐ **Proband** 2052

Proband Specimen Type*: ☐ DBS ☐ Whole blood

☐ **Family Member 1** 2053

Family Member Name _____

Family Member DOB _____

Specimen Type*: ☐ DBS ☐ Whole blood ☐ Saliva

☐ **Family Member 2** 2053

Family Member Name _____

Family Member DOB _____

Specimen Type*: ☐ DBS ☐ Whole blood ☐ Saliva

ICD Code (Required): _____

Hospital/Laboratory Billing Information

(Hospital billing is required for all Medicare patients – both inpatients and outpatients.)

Athena Account # (if assigned) _____

CLIA # _____

Purchase Order # (if available) _____

Billing Contact _____

Email _____

Phone _____

Fax _____

Hospital/Lab Name _____

Address _____

City _____

State _____ Zip _____

Patient Identification

NOTE: Two forms of patient ID must be listed on EACH specimen.

Patient Name _____
First Last

Patient ID # (if available) _____

DOB _____ Sex: ☐ Male ☐ Female ☐ Unknown

Age _____

Mailing Address _____

City _____ State _____ Zip _____

Phone #1 _____ ☐ Day ☐ Eve ☐ Cell

Phone #2 _____ ☐ Day ☐ Eve ☐ Cell

Authorization to Use De-identified Specimen for Research. Test results are confidential and will only be reported as authorized by the patient or the patient's authorized representative or consistent with applicable state and federal law. To promote medical understanding and develop better health insights, Quest Diagnostics requests the patient's permission to use the specimen *in a de-identified way* (without identifying the test subject) for research, educational studies, commercial purposes and/or publication. Your name or other personal identifying information will not be used in or linked to the results of any studies or publications. You are not required to consent to any of these uses, and the decision to consent to the use of the specimen for *such purposes will not in any way affect processing or testing of the specimen, the test results or the services provided by Athena Diagnostics in connection with this testing.* Please indicate your choice regarding the use of the de-identified specimen by checking the line next to the appropriate option below.

I consent to the use of my de-identified specimen for research: ☐ **Yes** ☐ **No**

_____
Signature of Patient, Parent or Legally Authorized Representative Date

_____
Printed Name of Patient, Parent or Legally Authorized Representative

_____
Relationship to Patient if Signatory is Someone Other than Patient

Authorized Result Report Recipients
Required Physician Information

NPI # _____ Athena Acct # _____

Name _____
First Last

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Laboratory Information

Lab Name _____

Address _____

Phone _____ Fax _____

Email _____

***2.0 mL (1.0 mL minimum) whole blood EDTA (lavender top) tube.**
***Do not eat, drink, smoke or chew gum 30 minutes prior to saliva collection. Saliva must be collected using a Oragene OGD-500 collection device.**
***One blood spot card required with 5 blood spots preferred (2 spots minimum). Please allow the spots to dry fully before placing in any packaging, approximately three hours.**

NOTE: Specimen(s) must be labeled with two of the following forms of identification: name, date of birth, last four digits of SS#, patient ID no. These same two forms of ID must be indicated on the test requisition. Reflex testing will be performed at an additional charge.

Physician Attestation of 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 Diagnostics® lab. The company offers a blanket PAIC that can be signed for all future orders.

I warrant that I have obtained both oral and written consent using the **Patient Informed Consent Form for Genetic Testing** provided by Athena Diagnostics. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person).

_____ _____
Medical Practitioner Signature Date Printed Name of Medical Practitioner NPI

Patient Informed Consent Form for Genetic Testing is available at AthenaDiagnostics.com/consent.

Athena Diagnostics, Inc., 200 Forest Street, 2nd Floor, Marlborough, MA 01752 • 800.394.4493 • Fax 610.271.6085 • AthenaDiagnostics.com

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Family member information

If ordering trio or duo testing, please provide the names and relationship to proband of additional family members:

Family Member Name 1: _____

Relationship to Proband: _____

Family Member Name 2: _____

Relationship to Proband: _____

Proband Information

Reason(s) for referral for NewbornDx™ Advanced Sequencing Evaluation, ie, what was the initial presenting symptom?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Age of onset of initial presenting symptom: _____

Ethnicity (check all that apply):

☐ African or descended from the African continent ☐ Ashkenazi Jewish

☐ American Indian or Alaskan Native ☐ Asian ☐ Cajun/Creole

☐ Central or South American ☐ French Canadian ☐ Hispanic or Latino

☐ Middle Eastern ☐ Pacific Islander or Native Hawaiian

☐ Sephardic Jewish ☐ Western/Northern European

☐ Other (please specify): _____

_____

Is there a family history of a similar or related disorder? ☐ Yes ☐ No

Consanguinity (related by blood, eg, parents related by blood)?

Yes ☐ No ☐ Unsure ☐ If yes, please specify: _____

_____

History of a bone marrow transplant: ☐ Yes* ☐ No

*If yes, please contact 1.800.394.4493 ext. 2031 to speak to a Genomic Science Specialist before sending any samples.

Previous genetic testing

Please attach any relevant results to this form for review.

Chromosomes/Microarray analysis ☐ No results/not performed ☐ Yes/results:

_____

_____

_____

_____

_____

_____

Biochemical studies ☐ No results/not performed ☐ Yes/results:

_____

_____

_____

_____

_____

_____

Other molecular studies, including prenatal testing:

_____

_____

_____

_____

_____

_____

Please fill out the below information based on the history of the patient being tested. Clinic notes should also be submitted. This information is essential to correlate results found using the NewbornDx™ Advanced Sequencing Evaluation. The laboratory may contact the ordering clinician if more information is necessary.

Clinical details

Date of last clinical exam: _____

Biological sex: ☐ Male ☐ Female

☐ Other (please specify): _____

Head circumference: _____ %tile

Weight: _____ %tile

Height: _____ %tile

Common diagnoses (please provide more information about these common diagnoses using the check boxes on the next page):

☐ Ambiguous genitalia
☐ Congenital heart defect
☐ Dysmorphic features
☐ Hypotonia
☐ Multiple congenital anomalies
☐ Structural brain abnormalities
☐ Developmental delay
☐ Failure to thrive
☐ Metabolic acidosis
☐ Seizures

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Cancer
- ☐ Type of cancer: _____
- ☐ Age of diagnosis: _____
- ☐ Family history of cancer and affected relatives: _____

Cardiovascular
- ☐ Anemia
- ☐ Aortic root dilation
- ☐ Arrhythmia
- ☐ Atrial septal defect
- ☐ Bicuspid aortic valve
- ☐ Cardiomyopathy
- ☐ Coarctation of aorta
- ☐ EKG abnormality
- ☐ Mitral valve prolapse
- ☐ Patent ductus arteriosus
- ☐ Patent foramen ovale
- ☐ Teratology of Fallot
- ☐ Thrombocytopenia
- ☐ Thrombosis
- ☐ Tortuosity
- ☐ Truncus arteriosus
- ☐ Ventricular abnormality
- ☐ Ventricular septal defect
- ☐ Other: _____

Craniofacial
- ☐ Bifid uvula
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Craniosynostosis
- ☐ Epicanthal folds
- ☐ Hypertelorism
- ☐ Hypotelorism
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ Micrognathia
- ☐ Nose abnormality
- ☐ Palpebral fissures
- ☐ Philtrum abnormality
- ☐ Teeth abnormality
- ☐ Tongue abnormality
- ☐ Other: _____

Cognitive development
- ☐ ADD/ADHD
- ☐ Autism spectrum disorder
- ☐ Developmental delay
- ☐ Developmental regression
- ☐ Intellectual disability
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe
  - ☐ Profound
- ☐ Motor milestones delayed
- ☐ Speech delay
- ☐ Other: _____

Ear & hearing
- ☐ Deafness
  - ☐ Acquired
  - ☐ Congenital
  - ☐ Bilateral
  - ☐ Unilateral
  - ☐ Conductive
  - ☐ Sensorineural
- ☐ Low-set ears
- ☐ Pinna abnormality
- ☐ Preauricular pit
- ☐ Preauricular skin tag
- ☐ Other: _____

Endocrine
- ☐ Adrenal gland abnormality
- ☐ Adrenal insufficiency
- ☐ Cushing syndrome
- ☐ Diabetes insipidus
- ☐ Diabetes mellitus
- ☐ Growth hormone deficiency
- ☐ Hirsutism
- ☐ Immunologic abnormality
  - Specify: _____
- ☐ Obesity
- ☐ Pancreatic insufficiency
- ☐ Parathyroid dysfunction
- ☐ Thyroid dysfunction
- ☐ Other: _____

Eye defects & vision
- ☐ Amblyopia
- ☐ Aniridia
- ☐ Anophthalmia
- ☐ Blue sclerae
- ☐ Cataracts
  - ☐ Congenital
  - ☐ Postnatal
- ☐ Cherry red spot
- ☐ Coloboma
- ☐ Corneal abnormality
- ☐ Ectopia lentis
- ☐ Microphthalmia
- ☐ Nystagmus
- ☐ Optic Atrophy
- ☐ Ptosis
- ☐ Retinitis pigmentosa
- ☐ Strabismus
- ☐ Visual impairment
  - ☐ Blind
  - ☐ Cortical
  - ☐ Myopia
- ☐ Other: _____

Gastrointestinal
- ☐ Anal malformation
- ☐ Constipation (chronic)
- ☐ Crohn's disease
- ☐ Diarrhea (chronic)
- ☐ Esophageal atresia
- ☐ Gastroesophageal reflux
- ☐ Gastroparesis
- ☐ Hepatic failure
- ☐ Hepatomegaly
- ☐ Hirschsprung disease
- ☐ Inflammatory bowel disease
- ☐ Intestinal pseudo-obstruction
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Splenomegaly
- ☐ Vomiting (episodic/cyclic)
- ☐ Tracheoesophageal fistula
- ☐ Other: _____

Genitourinary
- ☐ Ambiguous genitalia
- ☐ Cryptorchidism
- ☐ Hypogonadism
- ☐ Hypospadias
- ☐ Kidney abnormality
  - ☐ Agenesis
  - ☐ Horseshoe
  - ☐ Partially duplicated
  - ☐ Polycystic
- ☐ Ovarian streak
- ☐ Polycystic ovarian syndrome
- ☐ Testicular abnormality
- ☐ Ureter abnormality
- ☐ Urethra abnormality
- ☐ Other: _____

Hair & skin
- ☐ Albinism
- ☐ Blistering

Hair & skin (continued)
- ☐ Cafe-au-lait spots
- ☐ Hair
  - ☐ Alopecia
  - ☐ Brittle
  - ☐ Coarse
  - ☐ Hypopigmentation
- ☐ Hemangioma
- ☐ Hyperextensible skin
- ☐ Hyperpigmented macule
- ☐ Hypopigmented macule
- ☐ Hypertrichosis
- ☐ Ichthyosis
- ☐ Infections
- ☐ Lipoma
- ☐ Nail abnormality
- ☐ Neurofibroma
- ☐ Rash
- ☐ Other: _____

Metabolic
- ☐ Acidosis
  - ☐ Lactic
  - ☐ Metabolic
- ☐ Creatinine Phosphokinase (abnormal)
- ☐ CSF lactate level (abnormal)
- ☐ Dicarboxylic aciduria
- ☐ Hyperammonemia
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Hypoammonemia
- ☐ Ketosis
- ☐ Organic aciduria
- ☐ Plasma carnitine (abnormal)
- ☐ Serum creatine (abnormal)
- ☐ Serum pyruvate (abnormal)
- ☐ Other: _____

Musculoskeletal
- ☐ Contractures
- ☐ Fractures
- ☐ Hemihypertrophy
- ☐ Hyperlordosis
- ☐ Hypermobility
- ☐ Hypertonia
- ☐ Hypotonia
- ☐ Kyphosis
- ☐ Muscle atrophy
- ☐ Muscular dystrophy
- ☐ Myopathy
- ☐ Myotonia
- ☐ Oligodactyly
- ☐ Overgrowth
- ☐ Polydactyly
- ☐ Rib defects
- ☐ Scoliosis
- ☐ Short stature
- ☐ Skeletal dysplasia
- ☐ Spina bifida
- ☐ Syndactyly
- ☐ Talipes equinovarus
- ☐ Tall stature
- ☐ Vertebral anomalies
- ☐ Other: _____

Neurologic
- ☐ Areflexia
- ☐ Ataxia
- ☐ Chorea
- ☐ Dystonia
- ☐ Epileptic encephalopathy
- ☐ Neuropathy
- ☐ Seizures
  - ☐ Absence
  - ☐ Atonic
  - ☐ Febrile
  - ☐ Generalized clonic
  - ☐ Generalized myoclonic
  - ☐ Generalized tonic
  - ☐ Generalized tonic-clonic
  - ☐ Infantile spasms
- ☐ Spasticity
- ☐ Other: _____

Pre/perinatal history
- ☐ Conceived via artificial reproductive technology
- ☐ Congenital diaphragmatic hernia
- ☐ Cystic hygroma
- ☐ Encephalocele
- ☐ Increased nuchal translucency
- ☐ Intrauterine growth restriction
- ☐ Oligohydramnios
- ☐ Omphalocele
- ☐ Polyhydramnios
- ☐ Prematurity
- ☐ Teratogen exposure
  - Specify: _____
- ☐ Other: _____

Respiratory
- ☐ Apnea
- ☐ Asthma
- ☐ Bronchiectasis
- ☐ Hyperventilation
- ☐ Hypoventilation
- ☐ Pneumothorax
- ☐ Recurrent infections
- ☐ Respiratory failure
- ☐ Respiratory insufficiency
- ☐ Other: _____

Structural brain abnormalities
- ☐ Aplasia/hypoplasia of the cerebellar vermis
- ☐ Aplasia/hypoplasia of the cerebellum
- ☐ Basal ganglia abnormality
- ☐ Brain atrophy
- ☐ Brainstem abnormality
- ☐ Cerebral dysmyelination
- ☐ Cerebral hypomyelination
- ☐ Cerebral white matter abnormality
- ☐ Corpus callosum abnormality
- ☐ Cortical dysplasia
- ☐ Encephalocele
- ☐ Holoprosencephaly
- ☐ Hydrocephalus
- ☐ Leukoencephalopathy
- ☐ Leukodystrophy
- ☐ Lissencephaly
- ☐ Neuronal migration abnormality
- ☐ Pachgyria
- ☐ Polymicrogyria
- ☐ Ventriculomegaly
- ☐ Other: _____

Other
- ☐ Allergies (severe)
- ☐ Fever (episodic)
- ☐ Failure to thrive
- ☐ Heterotaxy
- ☐ Lethargy
- ☐ Organomegaly
- ☐ Pain (chronic)
- ☐ Other: _____

Attach any imaging or laboratory results, including but not limited to: prenatal testing, biopsies, EMG, EEG, imaging, metabolic, molecular, etc.

Questions? To speak with a Genomic Science Specialist, please call: 1.800.394.4493 ext. 2031

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Any additional comments?

Form Submission Instructions

When the form is complete please include a printed copy with the samples.

Ordering Checklist

- ☐ Completed requisition form
- ☐ Clinical history completed
- ☐ Any clinical notes should be sent with the specimen(s)
- ☐ Patient sample either blood spot card or whole blood in a lavender top tube
- ☐ Family member(s) samples either blood spot cards, whole blood in a lavender top tube, or saliva
- ☐ Family member(s) name, date of birth, and relationship

NOTE: Specimen(s) must be labeled with two of the following forms of identification: name, date of birth, last four digits of SS#, patient ID #. These same two forms of ID must be indicated on the test requisition.

Athena Diagnostics Client Service Representatives are available from 8:30AM to 9:00PM Eastern Time (US). Customers in the US and Canada please call toll-free

1.800.394.4493

(Non-US customers please call 508.756.2886 or fax 610.271.6085.)

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