# Athena Diagnostics Endocrinology Client Test Requisition (April 2017)

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.

NOTE: Client services is now available until 9:00 PM ET. They can be reached at 800-394-4493, option 2.

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**Fields in red indicate required information**

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

**If you wish to have Athena Diagnostics bill the insurance company directly, please use the Insurance Test Requisition.**

**Please note: Athena Diagnostics must bill hospitals directly for all Medicare hospital inpatient and outpatient testing.**

**Who Should Athena Diagnostics Contact with Questions About this Order?**

Name _____

Phone _____

Fax _____

Email _____

**Tests Ordered**

**Important:** Write in the test code and test name (see list on reverse).

Code _____ Name _____

Code _____ Name _____

**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 tube.**

Patient Name _____ (First / Last)

Patient ID # (if available) _____

Last Four Digits of SS# _____ Sex: ☐ Male ☐ Female ☐ Unknown

DOB _____

Age _____

Mailing Address _____

_____

City _____ State _____ Zip _____

Phone #1 _____ ☐ Day ☐ Eve ☐ Cell

Phone #2 _____ ☐ Day ☐ Eve ☐ Cell

**Authorization to Use De-identified Specimen for Research.** To promote medical understanding and develop better health insights, Athena Diagnostics requests your permission to use your specimen in a de-identified way (without identifying information) for research, educational studies, commercial purposes and/or publication, if appropriate. Your name or other personal identifying information will not be used in or linked to the results of any studies and publications. Your refusal to have your specimen used or not used for research purposes will not affect processing or testing of your specimen, your test results or the service support provided by Athena Diagnostics to your physician. Please indicate your approval by checking the box next to **Yes** or denial by checking the box next to **No**.

**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 Date

_____

Relationship to Patient if Signatory is Someone Other than Patient

**Authorized Result Report Recipients Required Physician Information**

NPI # _____ UPIN # _____

Name _____ (First / Last)

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

**Laboratory Information**

CLIA # _____

Lab Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

**Indications for Testing (Check One)**

☐ Diagnostic (symptomatic) ☐ Predictive (asymptomatic) ☐ Prenatal ☐ Carrier ☐ Family Testing

**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 acknowledgement from the ordering medical practitioner. The signed acknowledgement 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. 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.

**Type of Specimen** ☐ Whole Blood ☐ CVS: Cultured ☐ Amniotic Fluid: Cultured Date Collected _____

**NOTE: Specimen tube(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 also be indicated on the test requisition. Reflex testing will be performed at an additional charge.**

**Note:** Test requisitions become outdated. For the most accurate and up-to-date test offering, please visit AthenaDiagnostics.com.

**Athena Diagnostics, Inc., 200 Forest Street, 2nd Floor, Marlborough, MA 01752 • 800-394-4493 • Fax 774-843-3721 • AthenaDiagnostics.com**

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| Test Code | Test Name | Genes Included |
|---|---|---|
| **Adrenal Disorders** | | |
| ☐ **816** | **Primary Adrenal Insufficiency Evaluation** | ABCD1, NR0B1, AIRE |
| ☐ 812 | Autoimmune Polyglandular Syndrome (AIRE) Evaluation | |
| ☐ 815 | ABCD1 (Adrenoleukodystrophy) DNA Sequencing Test | |
| ☐ 814 | NR0B1 (Adrenal Hypoplasia Congenita) DNA Sequencing Test | |
| ☐ 881 | Endocrine Hypertension (HSD11B2) Evaluation | |
| ☐ 855 | PHEX (Hypophosphatemic Rickets) DNA Sequencing Test | |
| ☐ 856 | FGF23 (Hypophosphatemic Rickets) DNA Sequencing Test | |
| ☐ **879** | **Congenital Adrenal Hyperplasia (CAH) Evaluation** CYP21A2 sequencing and deletion, CYP11B1 sequencing | |
| ☐ 880 | CYP21A2 (CAH) Evaluation | |
| | Required: Indication for Study (check one or more below): | |
| | ☐ Family history of CAH | |
| | ☐ Virilization (ambiguous genitalia) | |
| | ☐ Salt Wasting | |
| | ☐ Parent/sibling of CAH patient | |
| | ☐ 17-hydroxyprogesterone (17-OHP) elevated concentration in serum | |
| | ☐ Other_____ | |
| ☐ 875 | CYP11B1 (CAH) DNA Sequencing Test | |
| ☐ 874 | Lipoid CAH (STAR) DNA Sequencing Test | |
| ☐ 877 | CYP17A1 DNA Sequencing Test | |
| ☐ 878 | HSD3B2 DNA Sequencing Test | |
| ☐ 881 | Endocrine Hypertension (HSD11B2) Evaluation | |
| **Bone Diseases** | | |
| ☐ **860** | **Osteogenesis Imperfecta Evaluation** | COL1A1, COL1A2 |
| ☐ 861 | COL1A1 (OI) DNA Sequencing Test | |
| ☐ 862 | COL1A2 (OI) DNA Sequencing Test | |
| ☐ 811 | LRP5 (OPPG) DNA Sequencing Test | |
| ☐ 821 | LRP5 Idiopathic Osteoporosis (IOP) DNA Sequencing Test | |
| ☐ **857** | **Hypophosphatemic Rickets Evaluation** | PHEX, FGF23 |
| ☐ 855 | PHEX (Hypophosphatemic Rickets) DNA Sequencing Test | |
| ☐ 856 | FGF23 (Hypophosphatemic Rickets) DNA Sequencing Test | |
| **Congenital Hyperinsulinism** | | |
| ☐ **819** | **Congenital Hyperinsulinism Evaluation** GLUD1, GCK, KCNJ11, ABCC8 | |
| | Indication for Study (check one or more below): | |
| | ☐ Diazoxide Responsive | |
| | ☐ Diazoxide Non-Responsive | |
| | ☐ Hypoglycemic | |
| | ☐ Large for Gestational Age (LGA) | |
| | ☐ Other (describe) _____ | |
| ☐ 822 | GLUD1 (CHI) DNA Sequencing Test | |
| ☐ 823 | GCK (CHI) DNA Sequencing Test | |
| ☐ 826 | KCNJ11 (CHI) DNA Sequencing Test | |
| ☐ 827 | ABCC8 (CHI) DNA Sequencing Test | |
| ☐ **42** | **CH Parental Testing – To augment child/proband diagnosis** | |
| | **For expedited diagnosis of proband, send parental testing samples as soon as possible and provide information below.** | |
| | ☐ Mother ☐ Father | |
| | Proband Name/Accession #_____ | |

| Test Code | Test Name | Genes Included |
|---|---|---|
| **Diabetes** | | |
| ☐ **8800** | **Monogenic Diabetes (MODY) Four-Gene Evaluation** | HNF1A, GCK, HNF4A, HNF1B |
| ☐ **8801** | **Monogenic Diabetes (MODY) Three-Gene Evaluation** | HNF1A, GCK, HNF1B |
| ☐ **8802** | **Monogenic Diabetes (MODY) Two-Gene Evaluation** | HNF1A, GCK |
| ☐ **885** | **Monogenic Diabetes (MODY) Five-Gene Evaluation** | HNF1A, GCK, HNF4A, HNF1B, IPF1 |
| ☐ 802 | HNF4A (MODY1) DNA Sequencing and Deletion Test | |
| ☐ 803 | GCK (MODY2) DNA Sequencing and Deletion Test | |
| ☐ 804 | TCF1 (MODY3) DNA Sequencing and Deletion Test | |
| ☐ 834 | IPF1 (MODY4) DNA Sequencing Test | |
| ☐ 805 | TCF2 (MODY5) DNA Sequencing and Deletion Test | |
| ☐ 837 | CEL (MODY8) Mutation Analysis | |
| ☐ **882** | **Neonatal Diabetes Mellitus Evaluation** | IPF1, GCK, KCNJ11, INS, ABCC8 |
| ☐ 841 | IPF1 (NDM) DNA Sequencing Test | |
| ☐ 842 | GCK (NDM) DNA Sequencing Test | |
| ☐ 843 | KCNJ11 (NDM) DNA Sequencing Test | |
| ☐ 853 | INS (NDM) DNA Sequencing Test | |
| ☐ 876 | ABCC8 (NDM) DNA Sequencing Test | |
| **Nephrogenic Diabetes** | | |
| ☐ **854** | **Nephrogenic Diabetes Insipidus Evaluation** | AVPR2, AQP2 |
| ☐ 851 | Nephrogenic Diabetes Insipidus (AVPR2) DNA Sequencing Test | |
| ☐ 852 | AQP2 (Nephrogenic Diabetes Insipidus) DNA Sequencing Test | |
| **Familial Cancer Syndromes** | | |
| ☐ 818 | MEN1 DNA Sequencing Test | |
| ☐ **889** | **Pheochromocytoma Evaluation** | RET, VHL, SDHB |
| ☐ 813 | MEN2 (RET) DNA Sequencing Test | |
| ☐ 858 | von Hippel-Lindau Syndrome (VHL) DNA Sequencing Test | |
| ☐ 888 | SDHB DNA Sequencing Test | |
| **Familial Hypocalciuric Hypercalcemia** | | |
| ☐ 829 | Familial Hypocalciuric Hypercalcemia (CASR) DNA Sequencing Test | |
| **Familial Testing – Targeted Analysis** | | |
| ☐ **185** | **Familial DNA Sequence Evaluation** This test detects previously identified sequence variants in at-risk family members. This test is available for HNF4A, GCK, TCF1, IPF1, TCF2, COL1A1, COL1A2, MEN1, and RET mutations | |
| | Proband Accession #_____ Relationship _____ | |
| **Lipid Disorders** | | |
| ☐ **895** | **Hypercholesterolemia Evaluation** | LDLR, APOB |
| ☐ 894 | LDLR (Hypercholesterolemia) DNA Sequencing Test | |
| ☐ 893 | ApoB Mutation Analysis | |
| **Obesity** | | |
| ☐ **884** | **Early Onset Obesity Evaluation** | LEPR, MC4R |
| ☐ 883 | Early Onset Obesity (LEPR) DNA Sequencing Test | |
| ☐ 640 | Early Onset Obesity (MC4R) DNA Sequencing Test | |
| ☐ **887** | **Bardet-Biedl Syndrome Evaluation** | BBS1, BBS2, BBS10 |
| ☐ 871 | BBS1 (BBS) DNA Sequencing Test | |
| ☐ 872 | BBS2 (BBS) DNA Sequencing Test | |
| ☐ 886 | BBS10 (BBS) DNA Sequencing Test | |

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|---|---|---|
| **Reproductive Disorders** | | |
| ☐ 817 | Male Precocious Puberty (LHCGR) DNA Sequencing Test | |
| ☐ **679** | **Complete Kallmann/IHH Evaluation** | CHD7, KAL1, PROK2, PROKR2, FGF8, FGFR1, GnRHR, GnRH1, KISS1R, TACR3 |
| ☐ **667** | **Normosmic Kallmann/IHH Evaluation** | PROK2, PROKR2, FGFR1, GnRHR, GnRH1, TACR3, KISS1R |
| ☐ **462** | **Anosmic Kallmann/IHH Evaluation** | KAL1, PROK2, PROKR2, FGF8, FGFR1, GnRHR, KISS1R |
| ☐ 173 | KAL1 DNA Sequencing Test | |
| ☐ 175 | PROK2 DNA Sequencing Test | |
| ☐ 180 | PROKR2 DNA Sequencing Test | |
| ☐ 195 | FGF8 DNA Sequencing Test | |
| ☐ 196 | FGFR1 DNA Sequencing Test | |
| ☐ 279 | GnRHR DNA Sequencing Test | |
| ☐ 343 | GnRH1 DNA Sequencing Test | |
| ☐ 358 | TACR3 DNA Sequencing Test | |
| ☐ 364 | KISS1R DNA Sequencing Test | |
| ☐ 461 | CHD7 DNA Sequencing Test | |

| Test Code | Test Name | Genes Included |
|---|---|---|
| **Short Stature** | | |
| ☐ **865** | **Combined Pituitary Hormone Deficiency Evaluation** | PROP1, POU1F1 |
| ☐ 863 | PROP1 (CPHD) DNA Sequencing Test | |
| ☐ 864 | POU1F1 (CPHD) DNA Sequencing Test | |
| ☐ **848** | **Growth Hormone Deficiency Evaluation** | GH1 and GHRHR Seq.; SHOX Seq. and Del. |
| ☐ 866 | GH1 (GHD) DNA Sequencing Test | |
| ☐ 868 | GHRHR (GHD) DNA Sequencing Test | |
| ☐ 847 | SHOX (GHD) DNA Sequencing and Deletion Test | |
| ☐ 867 | GHR DNA Sequencing Test | |
| **Noonan Syndrome** | | |
| ☐ 846 | Noonan Syndrome (PTPN11) DNA Sequencing Test | |
| ☐ **658** | **KRAS/RAF1/SOS1 DNA Sequencing Evaluation** | SOS1, RAF1, KRAS |
| ☐ 662 | SOS1 DNA Sequencing Test | |
| ☐ 663 | RAF1 DNA Sequencing Test | |
| ☐ 664 | KRAS DNA Sequencing Test | |

**Specimen Requirements:** 8 mL (6 mL minimum) whole blood collected in an EDTA (lavender-top) tube.

**NOTE: Specimen tube(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 also be indicated on the test requisition.**

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

**800-394-4493**

*(Non-U.S. customers please call 508-756-2886 or fax 774-843-3721.)*

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