Athena Diagnostics Endocrinology Client Test Requisition (April 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.

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) _____

DOB _____

Age _____

Sex: ☐ Male ☐ Female ☐ Unknown

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 # _____

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 ☐ DNA** 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.

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

Athena Diagnostics, Inc., 200 Forest Street, 2nd Floor, Marlborough, MA 01752 • 800-394-4493 • Fax 610-271-6085 • AthenaDiagnostics.com

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Test Code	Test Name	Genes Included
Adrenal Disorders		
☐ **816**	**Primary Adrenal Insufficiency Evaluation**	ABCD1, NROB1, AIRE
☐ 812	Autoimmune Polyglandular Syndrome (AIRE) Evaluation	
☐ 815	ABCD1 (Adrenoleukodystrophy) DNA Sequencing Test	
☐ 814	NROB1 (Adrenal Hypoplasia Congenita) 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		
☐ **885**	**Monogenic Diabetes (MODY) Five-Gene Evaluation**	HNF1A, GCK, HNF4A, HNF1B, IPF1
☐ **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
☐ 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 _____	
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	
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	

Note: Test requisitions become outdated.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

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Test Code	Test Name	Genes Included
Reproductive Disorders		
☐ 817	Male Precocious Puberty (LHCGR) DNA Sequencing Test	
☐ **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	
☐ **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

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	

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 610-271-6085)

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