

Athena Diagnostics Endocrinology Client Test Requisition (March 2018)



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.

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) _____

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 # _____

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

Endocrinology Client Test Requisition (March 2018)



Test Code	Test Name	Genes Included
Adrenal Disorders		
<input type="checkbox"/> 816	Primary Adrenal Insufficiency Evaluation	ABCD1, NROB1, AIRE
<input type="checkbox"/> 812	Autoimmune Polyglandular Syndrome (AIRE) Evaluation	
<input type="checkbox"/> 815	ABCD1 (Adrenoleukodystrophy) DNA Sequencing Test	
<input type="checkbox"/> 814	NROB1 (Adrenal Hypoplasia Congenita) DNA Sequencing Test	
<input type="checkbox"/> 879	Congenital Adrenal Hyperplasia (CAH) Evaluation	
	CYP21A2 sequencing and deletion, CYP11B1 sequencing	
<input type="checkbox"/> 880	CYP21A2 (CAH) Evaluation	
	Required: 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 _____	
<input type="checkbox"/> 875	CYP11B1 (CAH) DNA Sequencing Test	
<input type="checkbox"/> 874	Lipoid CAH (STAR) DNA Sequencing Test	
<input type="checkbox"/> 877	CYP17A1 DNA Sequencing Test	
<input type="checkbox"/> 878	HSD3B2 DNA Sequencing Test	
<input type="checkbox"/> 881	Endocrine Hypertension (HSD11B2) Evaluation	
Bone Diseases		
<input type="checkbox"/> 860	Osteogenesis Imperfecta Evaluation	COL1A1, COL1A2
<input type="checkbox"/> 861	COL1A1 (OI) DNA Sequencing Test	
<input type="checkbox"/> 862	COL1A2 (OI) DNA Sequencing Test	
<input type="checkbox"/> 811	LRP5 (OPPG) DNA Sequencing Test	
<input type="checkbox"/> 821	LRP5 Idiopathic Osteoporosis (IOP) DNA Sequencing Test	
<input type="checkbox"/> 857	Hypophosphatemic Rickets Evaluation	PHEX, FGF23
<input type="checkbox"/> 855	PHEX (Hypophosphatemic Rickets) DNA Sequencing Test	
<input type="checkbox"/> 856	FGF23 (Hypophosphatemic Rickets) DNA Sequencing Test	
Congenital Hyperinsulinism		
<input type="checkbox"/> 819	Congenital Hyperinsulinism Evaluation	
	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"/> 822	GLUD1 (CHI) DNA Sequencing Test	
<input type="checkbox"/> 823	GCK (CHI) DNA Sequencing Test	
<input type="checkbox"/> 826	KCNJ11 (CHI) DNA Sequencing Test	
<input type="checkbox"/> 827	ABCC8 (CHI) DNA Sequencing Test	
<input type="checkbox"/> 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.	
<input type="checkbox"/>	Mother <input type="checkbox"/> Father	
	Proband Name/Accession # _____	

Test Code	Test Name	Genes Included
Diabetes		
<input type="checkbox"/> 8800	Monogenic Diabetes (MODY) Four-Gene Evaluation	HNFA1, GCK, HNF4A, HNF1B
<input type="checkbox"/> 8801	Monogenic Diabetes (MODY) Three-Gene Evaluation	HNFA1, GCK, HNF1B
<input type="checkbox"/> 8802	Monogenic Diabetes (MODY) Two-Gene Evaluation	HNFA1, GCK
<input type="checkbox"/> 885	Monogenic Diabetes (MODY) Five-Gene Evaluation	HNFA1, GCK, HNF4A, HNF1B, IPF1
<input type="checkbox"/> 802	HNF4A (MODY1) DNA Sequencing and Deletion Test	
<input type="checkbox"/> 803	GCK (MODY2) DNA Sequencing and Deletion Test	
<input type="checkbox"/> 804	TCF1 (MODY3) DNA Sequencing and Deletion Test	
<input type="checkbox"/> 834	IPF1 (MODY4) DNA Sequencing Test	
<input type="checkbox"/> 805	TCF2 (MODY5) DNA Sequencing and Deletion Test	
<input type="checkbox"/> 837	CEL (MODY8) Mutation Analysis	
<input type="checkbox"/> 882	Neonatal Diabetes Mellitus Evaluation	IPF1, GCK, KCNJ11, INS, ABCC8
<input type="checkbox"/> 841	IPF1 (NDM) DNA Sequencing Test	
<input type="checkbox"/> 842	GCK (NDM) DNA Sequencing Test	
<input type="checkbox"/> 843	KCNJ11 (NDM) DNA Sequencing Test	
<input type="checkbox"/> 853	INS (NDM) DNA Sequencing Test	
<input type="checkbox"/> 876	ABCC8 (NDM) DNA Sequencing Test	
Nephrogenic Diabetes		
<input type="checkbox"/> 854	Nephrogenic Diabetes Insipidus Evaluation	AVPR2, AQP2
<input type="checkbox"/> 851	Nephrogenic Diabetes Insipidus (AVPR2) DNA Sequencing Test	
<input type="checkbox"/> 852	AQP2 (Nephrogenic Diabetes Insipidus) DNA Sequencing Test	
Familial Cancer Syndromes		
<input type="checkbox"/> 818	MEN1 DNA Sequencing Test	
<input type="checkbox"/> 889	Pheochromocytoma Evaluation	RET, VHL, SDHB
<input type="checkbox"/> 813	MEN2 (RET) DNA Sequencing Test	
<input type="checkbox"/> 858	von Hippel-Lindau Syndrome (VHL) DNA Sequencing Test	
<input type="checkbox"/> 888	SDHB DNA Sequencing Test	
Familial Hypocalciuric Hypercalcemia		
<input type="checkbox"/> 829	Familial Hypocalciuric Hypercalcemia (CASR) DNA Sequencing Test	
Familial Testing - Targeted Analysis		
<input type="checkbox"/> 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		
<input type="checkbox"/> 846	Noonan Syndrome (PTPN11) DNA Sequencing Test	
<input type="checkbox"/> 658	KRAS/RAF1/SOS1 DNA Sequencing Evaluation	SOS1, RAF1, KRAS
<input type="checkbox"/> 662	SOS1 DNA Sequencing Test	
<input type="checkbox"/> 663	RAF1 DNA Sequencing Test	
<input type="checkbox"/> 664	KRAS DNA Sequencing Test	
Obesity		
<input type="checkbox"/> 884	Early Onset Obesity Evaluation	LEPR, MC4R
<input type="checkbox"/> 883	Early Onset Obesity (LEPR) DNA Sequencing Test	
<input type="checkbox"/> 640	Early Onset Obesity (MC4R) DNA Sequencing Test	
<input type="checkbox"/> 887	Bardet-Biedl Syndrome Evaluation	BBS1, BBS2, BBS10
<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	

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



Test Code	Test Name	Genes Included
Reproductive Disorders		
<input type="checkbox"/> 817	Male Precocious Puberty (LHCGR) DNA Sequencing Test	
<input type="checkbox"/> 462	Anosmic Kallmann/IHH Evaluation	KAL1, PROK2, PROKR2, FGF8, FGFR1, GnRHR, KISS1R
<input type="checkbox"/> 173	KAL1 DNA Sequencing Test	
<input type="checkbox"/> 175	PROK2 DNA Sequencing Test	
<input type="checkbox"/> 180	PROKR2 DNA Sequencing Test	
<input type="checkbox"/> 195	FGF8 DNA Sequencing Test	
<input type="checkbox"/> 196	FGFR1 DNA Sequencing Test	
<input type="checkbox"/> 279	GnRHR DNA Sequencing Test	
<input type="checkbox"/> 343	GnRH1 DNA Sequencing Test	
<input type="checkbox"/> 358	TACR3 DNA Sequencing Test	
<input type="checkbox"/> 364	KISS1R DNA Sequencing Test	
<input type="checkbox"/> 461	CHD7 DNA Sequencing Test	
<input type="checkbox"/> 679	Complete Kallmann/IHH Evaluation	CHD7, KAL1, PROK2, PROKR2, FGF8, FGFR1, GnRHR, GnRH1, KISS1R, TACR3
<input type="checkbox"/> 667	Normosmic Kallmann/IHH Evaluation	PROK2, PROKR2, FGF8, FGFR1, GnRHR, GnRH1, TACR3, KISS1R

Test Code	Test Name	Genes Included
Short Stature		
<input type="checkbox"/> 865	Combined Pituitary Hormone Deficiency Evaluation	PROP1, POU1F1
<input type="checkbox"/> 863	PROP1 (CPHD) DNA Sequencing Test	
<input type="checkbox"/> 864	POU1F1 (CPHD) DNA Sequencing Test	
<input type="checkbox"/> 848	Growth Hormone Deficiency Evaluation	GH1 and GHRHR Seq.; SHOX Seq. and Del.
<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	

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

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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

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