

Athena Diagnostics Neurology Client Test Requisition (September 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.

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 _____

Patient ID # (if available) _____

DOB _____ Sex: Male

Age _____ 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 # _____ Athena Acct # _____

Name _____

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 Serum CSF Muscle 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 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 610-271-6085 • AthenaDiagnostics.com

Please tear at perforation

Athena Diagnostics Neurology Testing Services (September 2017)

Important: Please be sure to write in test code and test name in the Tests Ordered section on front.

Test Code	Ref. Spec.	Ref. Vol.	Tube Type
Cerebrovascular Disease (Stroke)			
<input type="checkbox"/> 1175	Notch3(CADASIL) Sequencing Test	B	8 mL L
<input type="checkbox"/> 1149	HTRA1 (CARASIL) Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1120	COL4A1 Sequencing Test* (CSVD)	B	8 mL L
<input type="checkbox"/> 1122	Complete CCM Sequencing and CNV Evaluation* (KRIT1 Seq./Del., CCM2 Seq./Del., PDCD10 Seq./Del.)	B	8 mL L
<input type="checkbox"/> 1152	KRIT1 (CCM1) Seq. and CNV Evaluation*	B	8 mL L
<input type="checkbox"/> 1106	CCM2 Seq. and CNV Evaluation*	B	8 mL L
<input type="checkbox"/> 1179	PDCD10 (CCM3) Seq. and CNV Evaluation*	B	8 mL L
Dementia			
<input type="checkbox"/> 178	ADmark® Alzheimer's Evaluation* (ApoE, Phospho-Tau, Total-Tau, Aβ42) (Symptomatic for Dementia) <i>(CSF must be in polypropylene tube and arrive on cold pack or frozen)</i>	C	2 mL P
<input type="checkbox"/> 109	ADmark® ApoE Genotype Analysis & Interpretation* (Symptomatic for Dementia)	B	8 mL L
<input type="checkbox"/> 177	ADmark® Phospho-Tau/Total-Tau/Aβ42 CSF Analysis & Interpretation (Symptomatic) <i>(CSF must be in polypropylene tube and arrive on cold pack or frozen)</i>	C	2 mL P
<input type="checkbox"/> 179	ADmark® Early-Onset Alzheimer's Evaluation* (PS-1, APP Seq./Dup., PS-2)	B	8 mL L
<input type="checkbox"/> 167	ADmark® PSEN1 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 168	ADmark® APP DNA Sequencing Test and Duplication Test*	B	8 mL L
<input type="checkbox"/> 169	ADmark® PSEN2 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 281	Frontotemporal Dementia (FTD) Evaluation* (MAPT, GRN, C9orf72)	B	8 mL L
<input type="checkbox"/> 209	C9orf72 (FTD) DNA Test*	B	8 mL L
<input type="checkbox"/> 204	GRN DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 205	MAPT DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1711	Autoimmune Rapidly Progressive Dementia Evaluation with Recombx® (Hu, MaTa, CV2, Amphiphysin, GAD65, NMDA, VGKC, LGII, CASPR2)	S	2 mL R
<input type="checkbox"/> 1714	Recombx® Hu Autoantibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL R
<input type="checkbox"/> 1716	Recombx® MaTa Autoantibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL R
<input type="checkbox"/> 1717	Recombx® CV2 Autoantibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL R
<input type="checkbox"/> 1718	Recombx® Amphiphysin Autoantibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL R
<input type="checkbox"/> 1705	GAD65 Antibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL R
<input type="checkbox"/> 1706	NMDA Receptor Antibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL R
<input type="checkbox"/> 1707	VGKC Antibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL R
<input type="checkbox"/> 1708	LGII Antibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL R
<input type="checkbox"/> 1709	CASPR2 Antibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL R
Developmental Disabilities			
<input type="checkbox"/> 1186	Primary Microcephaly Sequencing Evaluation* (ASPM, MCPHI, WDR62)	B	8 mL L
<input type="checkbox"/> 1092	ASPM Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1153	MCPHI Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1257	WDR62 Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1193	SHANK3 Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1192	SHANK2 Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1190	PTEN Sequencing Test*	B	5 mL L
<input type="checkbox"/> 795	Joubert Syndrome Evaluation* (TMEM67, TMEM216, AHI1, CEP290, NPHP1, CC2D2A)	B	8 mL L
<input type="checkbox"/> 792	TMEM67 DNA Sequencing Test*	B	8 mL L

Test Code	Ref. Spec.	Ref. Vol.	Tube Type
<input type="checkbox"/> 789	TMEM216 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 790	AHI1 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 791	CEP290 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 793	NPHP1 DNA Deletion Test*	B	8 mL L
<input type="checkbox"/> 794	CC2D2A DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 737	Smith-Lemli-Opitz Syndrome (DHCR7) DNA Test*	B	8 mL L
<input type="checkbox"/> 1256	VPS13B (COHI) Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1155	MECP2 Sequencing and CNV Evaluation*	B	8 mL L
<input type="checkbox"/> 148	Rett Syndrome (MECP2) Dup./Del. Test*	B	8 mL L
<input type="checkbox"/> 1038	ARX Seq. and CNV Evaluation (Intellectual Disability)*	B	8 mL L
<input type="checkbox"/> 1114	CDKL5 Seq. and CNV Evaluation (Atypical Rett)*	B	8 mL L
<input type="checkbox"/> 1194	SYNGAP1 Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1166	MEF2C Sequencing and CNV Evaluation*	B	4 mL L
<input type="checkbox"/> 1142	FOXP1 Sequencing and CNV Evaluation*	B	4 mL L
NOTE: Pediatric minimum for all Developmental Disabilities tests is 2 mL.			
Epilepsy			
<input type="checkbox"/> 6000	Epilepsy Advanced Sequencing and CNV Evaluation*	B	8 mL L
<input type="checkbox"/> 6008	Epilepsy Advanced Sequencing and CNV Evaluation - Generalized, Absence, Focal, Febrile and Myoclonic Epilepsies*	B	8 mL L
<input type="checkbox"/> 6010	Epilepsy Advanced Sequencing and CNV Evaluation - Epileptic Encephalopathy*	B	8 mL L
<input type="checkbox"/> 6018	Epilepsy Advanced Sequencing and CNV Evaluation - Developmental Brain Malformations*	B	8 mL L
<input type="checkbox"/> 6019	Epilepsy Advanced Sequencing and CNV Evaluation - Intellectual Disability*	B	8 mL L
<input type="checkbox"/> 6022	Epilepsy Advanced Sequencing and CNV Evaluation - Neuronal Ceroid Lipofuscinosis*	B	8 mL L
<input type="checkbox"/> 6023	Epilepsy Advanced Sequencing and CNV Evaluation - Epilepsy with Migraine*	B	8 mL L
<input type="checkbox"/> 6033	Epilepsy Advanced Sequencing and CNV Evaluation - Syndromic Disorders*	B	8 mL L
<input type="checkbox"/> 6038	Epilepsy Advanced Sequencing and CNV Evaluation - Infantile Spasms*	B	8 mL L
Please see website for the list of genes in each panel.			
<input type="checkbox"/> 5120	Autoimmune Epilepsy Evaluation GAD65, VGKC, CASPR2, LGII, NMDA	S	2 mL R
<input type="checkbox"/> 5101	GAD65 Neurological Syndrome Antibody Test (Epilepsy) (Single)	S	2 mL R
<input type="checkbox"/> 5102	VGKC Antibody Test (Epilepsy) (Single)	S	2 mL R
<input type="checkbox"/> 5103	CASPR2 Antibody Test (Epilepsy) (Single)	S	2 mL R
<input type="checkbox"/> 5104	LGII Antibody Test (Epilepsy) (Single)	S	2 mL R
<input type="checkbox"/> 5105	NMDA Receptor (NRI-subunit) Antibody Test (Epilepsy) (Single)	S	2 mL R
<input type="checkbox"/> 1131	Complete Tuberous Sclerosis Seq. and CNV Evaluation* (TSC1 Seq., TSC1 Del., TSC2 Seq., TSC2 Del.)	B	8 mL L
<input type="checkbox"/> 1245	TSC1 Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1236	TSC1 CNV Test*	B	8 mL L
<input type="checkbox"/> 508	TSC1 Deletion Analysis	B	8 mL L
<input type="checkbox"/> 1255	TSC2 Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1254	TSC2 CNV Test*	B	8 mL L
<input type="checkbox"/> 524	TSC2 DNA Deletion Test	B	8 mL L
<input type="checkbox"/> 523	TSC Familial DNA Seq. Mutation Evaluation*	B	8 mL L
Proband Accession # _____			
Relationship _____			

Test Code	Ref. Spec.	Ref. Vol.	Tube Type
<input type="checkbox"/> 1129	SCN1A Seq. and CNV Evaluation*	B	8 mL L
<input type="checkbox"/> 1191	SCN1A CNV Test*	B	8 mL L
<input type="checkbox"/> 537	SCN1A Deletion Test	B	8 mL L
<input type="checkbox"/> 1133	CSTB (EPM1) Seq. and Repeat Expansion Evaluation*	B	8 mL L
<input type="checkbox"/> 410	EPM1 DNA Test*	B	8 mL L
<input type="checkbox"/> 1036	ARX Seq. and CNV Evaluation (Epilepsy)*	B	8 mL L
<input type="checkbox"/> 1115	CDKL5 Seq. and CNV Evaluation (Epilepsy)*	B	8 mL L
<input type="checkbox"/> 4411	SLC2A1 DNA Sequencing Test	B	8 mL L
<input type="checkbox"/> 1003	GFAP (Alexander Disease) Seq. Test*	B	8 mL L
<input type="checkbox"/> 443	POLG DNA Seq. Test* (Alpers Syndrome)	B	8 mL L
NOTE: Pediatric minimum for all Epilepsy tests is 2 mL.			
Family Testing			
<input type="checkbox"/> 185	Familial DNA Sequence Evaluation* This test detects previously identified sequence variants in at-risk family members. This test cannot be applied to the TTR gene. For Familial TSC mutations, please order Code 523. Proband Accession # _____ Relationship _____	B	8 mL L
Hearing Loss			
<input type="checkbox"/> 329	Connexin Related Deafness Evaluation* (Connexin 26, Connexin 30)	B	8 mL L
<input type="checkbox"/> 321	Connexin 26 (GJB2) DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 319	Connexin 30 (GJB6) DNA Test*	B	8 mL L
Leukodystrophy			
<input type="checkbox"/> 1175	Notch3(CADASIL) Sequencing Test*	B	8 mL L
<input type="checkbox"/> 6106	Leukoencephalopathy with Vanishing White Matter Evaluation* (EIF2B1, EIF2B2, EIF2B3, EIF2B4, EIF2B5)	B	8 mL L
<input type="checkbox"/> 6101	EIF2B1 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 6102	EIF2B2 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 6103	EIF2B3 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 6104	EIF2B4 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 6105	EIF2B5 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 6107	ARSA DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 6108	ABCD1 DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1183	PLP1 Sequencing and CNV Evaluation*	B	8 mL L
<input type="checkbox"/> 6109	GJC2 DNA Sequencing Test*	B	8 mL L
Migraine			
<input type="checkbox"/> 1148	Hemiplegic Migraine Seq. Evaluation* (CACNA1A, ATP1A2, SCN1A)	B	8 mL L
<input type="checkbox"/> 1103	CACNA1A Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1101	ATP1A2 Sequencing Test*	B	8 mL L
<input type="checkbox"/> 1136	SCN1A Sequencing Test (FHM)* (Exons 3, 23, 26)	B	8 mL L
Mitochondrial Disorders			
<input type="checkbox"/> 575	Common Mitochondrial Disorders Evaluation* (POLG, MELAS, MERRF, NARP)	B	8 mL L
<input type="checkbox"/> 576	Progressive External Ophthalmoplegia Evaluation* (POLG, TWINKLE, ANTI, OPA1, MELAS)	B	8 mL L
<input type="checkbox"/> 577	Mitochondrial Neurogastrointestinal Encephalopathy (MNGIE) Evaluation* (TYMP, RRM2B, MELAS)	B	8 mL L
<input type="checkbox"/> 578	Mitochondrial Hepatoencephalopathic Evaluation* (POLG, DGUOK, MPV17, TWINKLE)	B	8 mL L
<input type="checkbox"/> 579	Mitochondrial Encephalomyopathic Evaluation* (TK2, RRM2B, POLG)	B	8 mL L
<input type="checkbox"/> 515	LHON mtDNA Evaluation* (LHON 11778, 3460, 14484)	B	8 mL L
<input type="checkbox"/> 474	POLG DNA Sequencing Test* (Related to all allelic disorders)	B	8 mL L
<input type="checkbox"/> 479	TWINKLE (PEO1/C10orf2) DNA Seq. Test* (Related to mtDNA depletion)	B	8 mL L
<input type="checkbox"/> 466	ANTI (SLC25A4) DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL L
<input type="checkbox"/> 469	OPA1 DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL L
<input type="checkbox"/> 484	TYMP DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL L
<input type="checkbox"/> 486	RRM2B DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL L

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

Test Code	Ref. Spec.	Ref. Vol.	Tube Type
<input type="checkbox"/> 487	DUOK DNA Sequencing Test* (Related to mtDNA depletion)	B 8 mL	L
<input type="checkbox"/> 488	MPV17 DNA Sequencing Test* (Related to mtDNA depletion)	B 8 mL	L
<input type="checkbox"/> 489	TK2 DNA Sequencing Test* (Related to mtDNA depletion)	B 8 mL	L
<input type="checkbox"/> 517	MELAS mtDNA Evaluation* (MELAS 3243, 3271, 3252, 3256, 3291, 13513)	B 8 mL	L
<input type="checkbox"/> 518	MERRF mtDNA Evaluation* (MERRF 8344, 8356, 8296, 8363)	B 8 mL	L
<input type="checkbox"/> 516	NARP mtDNA Evaluation* (NARP 8993)	B 8 mL	L
<input type="checkbox"/> 824	PDHA1 DNA Sequencing Test*	B 8 mL	L
Motor Neuron Diseases			
<input type="checkbox"/> 6520	Amyotrophic Lateral Sclerosis Advanced Evaluation* (ALS2, ANG, CHMPB2, C9ORF72, DCTN1, FIG4, FUS, OPTN, PFN1, SETX, SIGMARI, SOD1, SQSTM1, TARDBP, UBQLN2, VAPB, VCP)	B 8mL	L
<input type="checkbox"/> 6522	Nonprevalent Amyotrophic Lateral Sclerosis Advanced Sequencing Evaluation* (ALS2, ANG, CHMPB2, DCTN1, FIG4, FUS, OPTN, PFN1, SETX, SIGMARI, SQSTM1, TARDBP, UBQLN2, VAPB, VCP)	B 8mL	L
<input type="checkbox"/> 670	C9orf72 DNA Test*	B 8 mL	L
<input type="checkbox"/> 620	SOD1 DNA Sequencing Test*	B 8 mL	L
<input type="checkbox"/> 6601	HSP, Common Sporadic Evaluation* (SPAST, SPG7)	B 8 mL	L
<input type="checkbox"/> 6602	HSP, Supplemental Sporadic Evaluation* (ATLN, REEP1, KIF5A, NIPA1, KIAA0196, BSCL2, HSPD1, RTN2, SLC33A1, SPG11, CYP7B1, ZFYVE26, ALS2, AP5Z1, FA2H, KIF1A, PNPLA6, SACS, SPG20, SPG21, LICAM, PLP1)	B 8 mL	L
<input type="checkbox"/> 6610	HSP, Complete Dominant Evaluation* (SPAST, ATLN, REEP1, KIF5A, NIPA1, KIAA0196, BSCL2, HSPD1, RTN2, SLC33A1)	B 8 mL	L
<input type="checkbox"/> 6611	HSP, Common Dominant Evaluation* (SPAST, ATLN, REEP1, KIF5A)	B 8 mL	L
<input type="checkbox"/> 6612	HSP, Supplemental Dominant Evaluation* (NIPA1, KIAA0196, BSCL2, HSPD1, RTN2, SLC33A1)	B 8 mL	L
<input type="checkbox"/> 6620	HSP, Complete Recessive Evaluation* (SPG11, ZFYVE26, SPG7, CYP7B1, ALS2, AP5Z1, FA2H, KIF1A, PNPLA6, SACS, SPG20, SPG21)	B 8 mL	L
<input type="checkbox"/> 6621	HSP, Common Recessive Evaluation* (SPG11, ZFYVE26, SPG7)	B 8 mL	L
<input type="checkbox"/> 6622	HSP, Supplemental Recessive Evaluation* (CYP7B1, ALS2, AP5Z1, FA2H, KIF1A, PNPLA6, SACS, SPG20, SPG21)	B 8 mL	L
<input type="checkbox"/> 6630	HSP, Comprehensive Evaluation* (SPAST, SPG7, ATLN, REEP1, KIF5A, NIPA1, KIAA0196, BSCL2, HSPD1, RTN2, SLC33A1, SPG11, CYP7B1, ZFYVE26, ALS2, AP5Z1, FA2H, KIF1A, PNPLA6, SACS, SPG20, SPG21, LICAM, PLP1)	B 8 mL	L
<input type="checkbox"/> 6631	HSP, X-Linked Evaluation* (LICAM, PLP1)	B 8 mL	L
<input type="checkbox"/> 6509	SPG4 Evaluation*	B 8 mL	L
Individual HSP DNA Tests:			
<input type="checkbox"/> 531	Atlastin (SPG3A)*	<input type="checkbox"/> 632	Paraplegin (SPG7)*
<input type="checkbox"/> 633	Spatascin (SPG11)*	<input type="checkbox"/> 614	ZFYVE26 (SPG15)*
<input type="checkbox"/> 214	SMA Plus (Reflexive)* Testing is performed in this order: 1. SMN1 Del./SMN2 Del.; 2. SMN1 Seq.	B 4 mL	L
<input type="checkbox"/> 111	SMA Diagnostic Test (including SMN2 Copy Number)	B 4 mL	L
<input type="checkbox"/> 211	SMN DNA Sequencing Test* (only order if deletion testing has already been performed)	B 4 mL	L
<input type="checkbox"/> 444	SMA Carrier Screen (SMN1 Del./SMN2 Del. Test*)	B 4 mL	L
<input type="checkbox"/> 117	Kennedy's Disease (SBMA) DNA Test*	B 8 mL	L
<input type="checkbox"/> 6521	Atypical Spinal Muscular Atrophy Advanced Sequencing Evaluation* (BICD2, DYNC1H1, GARS, HSPB1, HSPB3, HSPB8, IGHMBP2, TRPV4, UBA1, VRK1)	B 8 mL	L
Movement Disorders			
<input type="checkbox"/> 6900	Ataxia, Complete Dominant Evaluation (ATXN1, ATXN2, ATXN3, CACNA1A, ATXN7, TBP, ATXN80S, ATXN10, PPP2R2B, ATN1, AFG3L2, KCNC3, PRKCG, SPTBN2, EEF2, FGF14, ITPR1, KCND3, PDYN, TGM6, TTBK2, VAMP1, KCNA1, CACNB4, SLC1A3, CACNA1A)	B 10 mL	L
<input type="checkbox"/> 6901	Ataxia, Common Repeat Expansion Evaluation (ATXN1, ATXN2, ATXN3, CACNA1A, ATXN7, TBP, ATXN80S, ATXN10)	B 8 mL	L
<input type="checkbox"/> 6903	Ataxia, Supplemental Dominant Evaluation (AFG3L2, KCNC3, PRKCG, SPTBN2, EEF2, FGF14, ITPR1, KCND3, PDYN, TGM6, TTBK2, VAMP1, KCNA1, CACNB4, SLC1A3, CACNA1A)	B 8 mL	L

Test Code	Ref. Spec.	Ref. Vol.	Tube Type						
<input type="checkbox"/> 6910	Ataxia, Complete Recessive Evaluation (FXN, APTX, ATM, SETX, TTPA, ADCCK3, AFG3L2, ANO10, FLVCR1, GRM1, MRE11A, MTPAP, SACS, SYNE1, SYT14, TDP1, SIL1, POLG)	B 8 mL	L						
<input type="checkbox"/> 6911	Ataxia, Supplemental Recessive Evaluation (APTX, ATM, SETX, TTPA, ADCCK3, AFG3L2, ANO10, FLVCR1, GRM1, MRE11A, MTPAP, SACS, SYNE1, SYT14, TDP1, SIL1, POLG)	B 8 mL	L						
<input type="checkbox"/> 6912	Episodic Apraxia Ataxia Advanced Sequencing Evaluation (APT, SETX)	B 8 mL	L						
<input type="checkbox"/> 6920	Episodic Ataxia Evaluation (CACNB4, KCNA1, SLC1A3, CACNA1A)	B 8 mL	L						
<input type="checkbox"/> 6930	Ataxia, Comprehensive Evaluation (ATXN1, ATXN2, ATXN3, CACNA1A, ATXN7, TBP, ATXN80S, ATXN10, PPP2R2B, ATN1, AFG3L2, KCNC3, PRKCG, SPTBN2, EEF2, FGF14, ITPR1, KCND3, PDYN, TGM6, TTBK2, VAMP1, KCNA1, CACNB4, SLC1A3, CACNA1A, FXN, APTX, ATM, SETX, TTPA, ADCCK3, AFG3L2, ANO10, FLVCR1, GRM1, MRE11A, MTPAP, SACS, SYNE1, SYT14, TDP1, SIL1, POLG)	B 10 mL	L						
<input type="checkbox"/> 349	Ataxia, Friedreich (FXN) Evaluation* (FRDA/FXN Seq., FRDA/FXN Expansion)	B 8 mL	L						
<input type="checkbox"/> 353	Ataxia-Telangiectasia (ATM) Evaluation* (ATM Seq., ATM Dup./Del.)	B 8 mL	L						
Individual Ataxia DNA Tests:									
<input type="checkbox"/> 371	SCA1*	<input type="checkbox"/> 672	SCA2*						
<input type="checkbox"/> 373	SCA6*	<input type="checkbox"/> 677	SCA7*						
<input type="checkbox"/> 387	SCA10*	<input type="checkbox"/> 285	SCA12*						
<input type="checkbox"/> 401	DRPLA*	<input type="checkbox"/> 383	POLG (MIRAS)*						
<input type="checkbox"/> 283	TTPA (AVED)*	<input type="checkbox"/> 348	FRDA/FXN Seq.*						
<input type="checkbox"/> 119	FRDA/FXN Expansion*	<input type="checkbox"/> 105	SCA3*						
<input type="checkbox"/> 402	Chorea Differential Evaluation* (DRPLA, HD)	<input type="checkbox"/> 384	SCA8*						
<input type="checkbox"/> 116	Huntington Disease Repeat Expansion Test*	<input type="checkbox"/> 388	SCA17*						
<input type="checkbox"/> 639	Isolated Dystonia Evaluation* (DYTI, THAP1)	<input type="checkbox"/> 108	DMPK DNA Test (DM1)*						
<input type="checkbox"/> 626	Dystonia (DYTI) DNA Test*	<input type="checkbox"/> 110	CNBP DNA Test (DM2)* (DM2 testing is not recommended for patients with early onset myotonic dystrophy)						
<input type="checkbox"/> 618	THAP1 DNA Sequencing Test* (DYT6)	<input type="checkbox"/> 128	CLCN1 DNA Sequencing Test*						
<input type="checkbox"/> 629	Complete Dopa-Responsive Dystonia (DYT5) Evaluation* (GCHI Seq., GCHI Del., TH Seq.)	<input type="checkbox"/> 146	SCN4A (Myotonia) DNA Sequencing Test*						
<input type="checkbox"/> 637	GCHI DNA Sequencing Test* (DYT5A)	<input type="checkbox"/> 585	CAPN3 Evaluation* (includes CAPN3 Seq., CAPN3 Del.)						
<input type="checkbox"/> 638	GCHI Deletion Test (DYT5A)*	<input type="checkbox"/> 5531	DMD Duplication/Deletion						
<input type="checkbox"/> 634	TH DNA Sequencing Test (DYT5B)*	<input type="checkbox"/> 183	DMD DNA Sequencing Test*						
<input type="checkbox"/> 624	SGCE DNA Sequencing Test (DYT11)*	<input type="checkbox"/> 100	Dystrophin Protein Test						
<input type="checkbox"/> 627	SGCE Deletion Test (DYT11)*	<input type="checkbox"/> 207	Early-Onset Myotonia Evaluation* (DM1, CLCN1, SCN4A)						
<input type="checkbox"/> 617	PNKD (MR-1) DNA Sequencing Test*	<input type="checkbox"/> 108	DMPK DNA Test (DM1)*						
<input type="checkbox"/> 588	Complete Parkinsonism Evaluation* (LRRK2, PARK2, PINK1, PARK7, SNCA)	<input type="checkbox"/> 110	CNBP DNA Test (DM2)* (DM2 testing is not recommended for patients with early onset myotonic dystrophy)						
<input type="checkbox"/> 558	LRRK2 DNA Sequencing Test*	<input type="checkbox"/> 128	CLCN1 DNA Sequencing Test*						
<input type="checkbox"/> 559	PARK2 (Parkin) DNA Sequencing Test*	<input type="checkbox"/> 146	SCN4A (Myotonia) DNA Sequencing Test*						
<input type="checkbox"/> 040	PARK2 (Parkin) Duplication/Deletion Test*	<input type="checkbox"/> 585	CAPN3 Evaluation* (includes CAPN3 Seq., CAPN3 Del.)						
<input type="checkbox"/> 542	PINK1 DNA Sequencing Test*	<input type="checkbox"/> Individual Limb Girdle Muscular Dystrophy Tests:	<input type="checkbox"/> 562	FKRP*					
<input type="checkbox"/> 058	PINK1 Deletion Test*	<input type="checkbox"/> 562	LMNA*	<input type="checkbox"/> 566	CAV3*				
<input type="checkbox"/> 554	PARK7 (DJ1) DNA Sequencing Test*	<input type="checkbox"/> 582	SGCA Duplication/Deletion Test*	<input type="checkbox"/> 583	SGCG Duplication/Deletion Test*				
<input type="checkbox"/> 047	PARK7 (DJ1) Deletion Test*	<input type="checkbox"/> 584	CAPN3 Duplication/Deletion Test*	<input type="checkbox"/> 561	Dysferlin Protein Blood Test* (must arrive on cold pack) Sample must be received within 72 hours of draw.				
<input type="checkbox"/> 557	Alpha Synuclein (SNCA) DNA Seq. Test*	<input type="checkbox"/> 571	Dysferlin Sequencing Test*	<input type="checkbox"/> 571	Dysferlin Sequencing Test*				
<input type="checkbox"/> 059	Alpha Synuclein (SNCA) Dup./Del. Test*	<input type="checkbox"/> 405	FSHD1 Southern Blot Test*	<input type="checkbox"/> 405	FSHD1 Southern Blot Test*				
<input type="checkbox"/> 1187	PRRT2 (Dyskinesia/IC) Seq. Test*	<input type="checkbox"/> 5905	FSHD Molecular Combing Test*	<input type="checkbox"/> 5905	FSHD Molecular Combing Test*				
Multiple Sclerosis				<input type="checkbox"/> 300	OPMD Repeat Expansion Test*				
<input type="checkbox"/> 112	NabFeron® (INFB-1) Neutralizing Antibody Test	<input type="checkbox"/> 490	Optic Atrophy Evaluation* (OPA1)	<input type="checkbox"/> 390	Optic Atrophy Evaluation* (OPA1)				
<input type="checkbox"/> 197	TY5ABRI® (Natalizumab) Antibody Test (See website for collection notes)	<input type="checkbox"/> 648	Neurofibromatosis Type 1 (NF1) Evaluation* (NF1 Sequencing, NF1 Deletion)	<input type="checkbox"/> 648	Neurofibromatosis Type 1 (NF1) Evaluation* (NF1 Sequencing, NF1 Deletion)				
<input type="checkbox"/> 193	AQP4 (NMO-IgG) Antibody Test	<input type="checkbox"/> 645	Neurofibromatosis Type 2 (NF2) Evaluation* (NF2 Seq., NF2 Dup./Del.)	<input type="checkbox"/> 645	Neurofibromatosis Type 2 (NF2) Evaluation* (NF2 Seq., NF2 Dup./Del.)				
Myasthenia Gravis				<input type="checkbox"/> 646	Neurofibromatosis Type 1 DNA Sequencing Test*				
<input type="checkbox"/> 482	MuSK Antibody Test	<input type="checkbox"/> 647	Neurofibromatosis Type 1 Deletion Test*	<input type="checkbox"/> 647	Neurofibromatosis Type 1 Deletion Test*				
<input type="checkbox"/> 1480	Titin Antibody Test	<input type="checkbox"/> 635	Neurofibromatosis Type 2 DNA Sequencing Test*	<input type="checkbox"/> 644	Neurofibromatosis Type 2 Duplication/Deletion Test*				
<input type="checkbox"/> 1481	RyR Autoantibody Test	<input type="checkbox"/> Note: Additional specimens accepted. Please contact Lab Director.	Paraneoplastic & Other Antibody Disorders of the CNS						
<input type="checkbox"/> 1483	LRP4 Autoantibody Test	<input type="checkbox"/> 4711	Paraneoplastic Neurological Syndromes Evaluation with Recombx®, Initial Assessment (Hu, Yo, CV2, MaTa, Ri, Amphiphysin)	<input type="checkbox"/> 4620	NeoComplete Paraneoplastic Evaluation with Recombx® (Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, VGCC, VGKC, Amphiphysin, gnAChR, NMDA, GAD65, LGI1, CASPR2)				
<input type="checkbox"/> 1490	AChR-Seronegative Myasthenia Gravis Evaluation	<input type="checkbox"/> 4640	Paraneoplastic Autoantibody Evaluation with Recombx®, CSF (Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, Amphiphysin, NMDA, LGI1, CASPR2)	<input type="checkbox"/> 4640	Paraneoplastic Autoantibody Evaluation with Recombx®, CSF (Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, Amphiphysin, NMDA, LGI1, CASPR2)				
<input type="checkbox"/> 1510	Acetylcholine Receptor Binding Antibody with Reflex to Musk Antibody	<input type="checkbox"/> 4724	NeoCerebellar Degeneration Paraneoplastic Profile with Recombx® (Hu, Yo, Zic4, CV2, MaTa, Ri, Amphiphysin, GAD65 Neurological Syndrome)	<input type="checkbox"/> 4722	NeoEncephalitis Paraneoplastic Evaluation with Recombx® (Hu, CV2, MaTa, VGKC, Amphiphysin, GAD65, LGI1, NMDA, CASPR2)				
<input type="checkbox"/> 1511	Acetylcholine Receptor Binding Antibody with Reflex to MuSK/LRP4 Antibodies	<input type="checkbox"/> 4725	NeoSensory Neuropathy Paraneoplastic Profile with Recombx® (Hu, CV2, Amphiphysin)	<input type="checkbox"/> 4727	Neuromyotonia Evaluation (CASPR2, VGKC)				
<input type="checkbox"/> 1513	Acetylcholine Receptor Binding Antibody	<input type="checkbox"/> Individual Recombx® Autoantibody Tests:	<input type="checkbox"/> 4684	CAR	<input type="checkbox"/> 4681	CV2	<input type="checkbox"/> 4682	Hu	
<input type="checkbox"/> 1514	Myasthenia Gravis Panel 2	<input type="checkbox"/> 4683	MaTa	<input type="checkbox"/> 4685	Ri	<input type="checkbox"/> 4686	Yo	<input type="checkbox"/> 4689	Zic4
<input type="checkbox"/> 1516	Acetylcholine Receptor Blocking Antibody	<input type="checkbox"/> 4689	Zic4						
<input type="checkbox"/> 1517	Acetylcholine Receptor Modulating Antibody								
<input type="checkbox"/> 1521	Myasthenia Gravis Panel 2 with Reflex to MuSK Antibody								
Neuromuscular Disorders									
<input type="checkbox"/> 5501	Muscular Dystrophy Advanced Evaluation	B 8 mL	L						
<input type="checkbox"/> 5502	Congenital Muscular Dystrophy Advanced Sequencing Evaluation	B 8 mL	L						

Test Code	Ref. Spec.	Ref. Vol.	Tube Type
<input type="checkbox"/> 5503	Congenital Myopathy Advanced Sequencing Evaluation	B 8 mL	L
<input type="checkbox"/> 5504	Distal Myopathy Advanced Sequencing Evaluation	B 8 mL	L
<input type="checkbox"/> 5505	Myofibrillar Myopathy Advanced Sequencing Evaluation	B 8 mL	L
<input type="checkbox"/> 5506	Myotonic Syndromes Advanced Sequencing Evaluation	B 8 mL	L
<input type="checkbox"/> 5507	Periodic Paralysis Advanced Sequencing Evaluation	B 8 mL	L
<input type="checkbox"/> 5508	Malignant Hyperthermia Advanced Sequencing Evaluation	B 8 mL	L
<input type="checkbox"/> 5518	Emery-Dreifuss Muscular Dystrophy Advanced Sequencing Evaluation	B 8 mL	L
<input type="checkbox"/> 5519	Limb Girdle Muscular Dystrophy Advanced Evaluation	B 8 mL	L
<input type="checkbox"/> 5511	Congenital Myasthenic Syndrome Advanced Sequencing Evaluation	B 8 mL	L
<input type="checkbox"/> 5530	DMD Evaluation	B 8 mL	L
NOTE: Please see website for the list of genes in each panel.			
<input type="checkbox"/> 5531	DMD Duplication/Deletion	B 8 mL	L
<input type="checkbox"/> 183	DMD DNA Sequencing Test*	B 8 mL	L
<input type="checkbox"/> 100	Dystrophin Protein Test	M 10 mg	C
<input type="checkbox"/> 207	Early-Onset Myotonia Evaluation* (DM1, CLCN1, SCN4A)	B 8 mL	L
<input type="checkbox"/> 108	DMPK DNA Test (DM1)*	B 8 mL	L
<input type="checkbox"/> 110	CNBP DNA Test (DM2)* (DM2 testing is not recommended for patients with early onset myotonic dystrophy)	B 8 mL	L
<input type="checkbox"/> 128	CLCN1 DNA Sequencing Test*	B 8 mL	L
<input type="checkbox"/> 146	SCN4A (Myotonia) DNA Sequencing Test*	B 8 mL	L
<input type="checkbox"/> 585	CAPN3 Evaluation* (includes CAPN3 Seq., CAPN3 Del.)	B 8 mL	L
Individual Limb Girdle Muscular Dystrophy Tests:			
<input type="checkbox"/> 562	FKRP*	<input type="checkbox"/> 562	LMNA*
<input type="checkbox"/> 566	CAV3*		
<input type="checkbox"/> 582	SGCA Duplication/Deletion Test*		
<input type="checkbox"/> 583	SGCG Duplication/Deletion Test*		
<input type="checkbox"/> 584	CAPN3 Duplication/Deletion Test*		
<input type="checkbox"/> 561	Dysferlin Protein Blood Test* (must arrive on cold pack) Sample must be received within 72 hours of draw.	B 10 mL	L
<input type="checkbox"/> 571	Dysferlin Sequencing Test*	B 8 mL	L
<input type="checkbox"/> 405	FSHD1 Southern Blot Test*	B 15 mL	L
<input type="checkbox"/> 5905	FSHD Molecular Combing Test*	B 15 mL	L
<input type="checkbox"/> 300	OPMD Repeat Expansion Test*	B 8 mL	L
<input type="checkbox"/> 490	Optic Atrophy Evaluation* (OPA1)	B 8 mL	L
Neuro-Oncology			
<input type="checkbox"/> 648	Neurofibromatosis Type 1 (NF1) Evaluation* (NF1 Sequencing, NF1 Deletion)	B 8 mL	L
<input type="checkbox"/> 645	Neurofibromatosis Type 2 (NF2) Evaluation* (NF2 Seq., NF2 Dup./Del.)	B 8 mL	L
<input type="checkbox"/> 646	Neurofibromatosis Type 1 DNA Sequencing Test*	B 8 mL	L
<input type="checkbox"/> 647	Neurofibromatosis Type 1 Deletion Test*	B 8 mL	L
<input type="checkbox"/> 635	Neurofibromatosis Type 2 DNA Sequencing Test*	B 8 mL	L
<input type="checkbox"/> 644	Neurofibromatosis Type 2 Duplication/Deletion Test*	B 8 mL	L
Note: Additional specimens accepted. Please contact Lab Director.			
Paraneoplastic & Other Antibody Disorders of the CNS			
<input type="checkbox"/> 4711	Paraneoplastic Neurological Syndromes Evaluation with Recombx®, Initial Assessment (Hu, Yo, CV2, MaTa, Ri, Amphiphysin)	S 2 mL	R
<input type="checkbox"/> 4620	NeoComplete Paraneoplastic Evaluation with Recombx® (Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, VGCC, VGKC, Amphiphysin, gnAChR, NMDA, GAD65, LGI1, CASPR2)	C 2 mL	P**
<input type="checkbox"/> 4640	Paraneoplastic Autoantibody Evaluation with Recombx®, CSF (Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, Amphiphysin, NMDA, LGI1, CASPR2)	C 2 mL	P**
<input type="checkbox"/> 4724	NeoCerebellar Degeneration Paraneoplastic Profile with Recombx® (Hu, Yo, Zic4, CV2, MaTa, Ri, Amphiphysin, GAD65 Neurological Syndrome)	S 2 mL	R
<input type="checkbox"/> 4722	NeoEncephalitis Paraneoplastic Evaluation with Recombx® (Hu, CV2, MaTa, VGKC, Amphiphysin, GAD65, LGI1, NMDA, CASPR2)	S 2 mL	R
<input type="checkbox"/> 4725	NeoSensory Neuropathy Paraneoplastic Profile with Recombx® (Hu, CV2, Amphiphysin)	S 2 mL	R
<input type="checkbox"/> 4727	Neuromyotonia Evaluation (CASPR2, VGKC)	S 2 mL	R
Individual Recombx® Autoantibody Tests:			
<input type="checkbox"/> 4684	CAR	<input type="checkbox"/> 4681	CV2
<input type="checkbox"/> 4683	MaTa	<input type="checkbox"/> 4682	Hu
<input type="checkbox"/> 4685	Ri	<input type="checkbox"/> 4686	Yo
<input type="checkbox"/> 4689	Zic4		

Important: Please be sure to write in test code and test name in the Tests Ordered section on front.

Test Code	Spec.	Vol.	Tube Type
<input type="checkbox"/> 449	LGII Antibody Test	S	2 mL R
<input type="checkbox"/> 499	CASPR2 Antibody Test	S	2 mL R
<input type="checkbox"/> 419	NMDA Receptor (NR1-subunit) Antibody Test	S	2 mL R
<input type="checkbox"/> 422	GAD65 Neurological Syndrome Antibody Test	S	2 mL R
<input type="checkbox"/> 475	LEMS (VGCC) Antibody Test	S	2 mL R
<input type="checkbox"/> 485	VGKC Antibody Test	S	2 mL R
<input type="checkbox"/> 4674	Recomb [®] Amphiphysin Autoantibody Test	S	2 mL R
<input type="checkbox"/> 428	Ganglionic AChR Antibody Test	S	2 mL R
Peripheral Neuropathy: Autoimmune			
<input type="checkbox"/> 3100	SensoriMotor Neuropathy Profile with Recomb[®] - Complete (Co-GM1 Quattro [®] , MAG [®] Dual Antigen [®] , Hu, GALOP [™] , SGPG, Sulfatide)	S	2 mL R
<input type="checkbox"/> 3148	Sensory Neuropathy Profile with Recomb[®] (MAG [®] Dual Antigen [®] , Hu, GALOP [™] , SGPG, Sulfatide)	S	2 mL R
<input type="checkbox"/> 3163	Motor Neuropathy Profile - Complete (Co-GM1 Quattro [®] , SGPG, MAG [®] Dual Antigen [®])	S	2 mL R
<input type="checkbox"/> 289	Multifocal Motor Neuropathy Evaluation* (Co-GM1 Quattro [®] , PMP22 Dup./Del.)	S	2 mL R
<input type="checkbox"/> 3155	Co-GM1 Quattro [®] Autoantibody Test	S	2 mL R
<input type="checkbox"/> 3127	MAG [®] Dual Antigen [®] Autoantibody Test	S	2 mL R
<input type="checkbox"/> 261	GALOP [™] Antibody Test	S	2 mL R
<input type="checkbox"/> 210	Sulfatide Antibody Test	S	2 mL R
<input type="checkbox"/> 160	GQIb Antibody Test	S	2 mL R
<input type="checkbox"/> 278	GD1a Antibody Test	S	2 mL R
<input type="checkbox"/> 272	Co-Asialo Antibody Test	S	2 mL R
<input type="checkbox"/> 273	Co-GD1b Antibody Test	S	2 mL R
<input type="checkbox"/> 271	Co-GM1 Antibody Test	S	2 mL R
Peripheral Neuropathy: Hereditary			
<input type="checkbox"/> 4010	CMT Advanced Evaluation - Initial Genetic Assessment (PMP22 Dup./Del., GJB1 (Cx32), MPZ, MFN2 Seq.)	B	8 mL L
<input type="checkbox"/> 4011	CMT Advanced Evaluation - Nonprevalent Axonal (GJB1 (Cx32) Del., NFL, GDIAP1, GARS,	B	8 mL L

Test Code	Spec.	Vol.	Tube Type
RAB7, HSPB1, DNM2, YARS, LMNA, TRPV4, HSPB8 Seq.)			
<input type="checkbox"/> 4012	CMT Advanced Evaluation - Nonprevalent Demyelinating (GJB1 (Cx32) Del., EGR2, LITAF, PMP22, PRX, GDIAP1, DNM2, YARS, SH3TC2, MTMR2, NDRG1, FGD4, FIG4, SBF2 Seq.)	B	8 mL L
<input type="checkbox"/> 4013	CMT Advanced Evaluation - Nonprevalent Demyelinating (Reflexive)* Testing is performed in this order: 1. PMP22 Dup./Del. If negative: 2. Cx32, PMP22, MFN2, MPZ, EGR2, LITAF, PRX, GDIAP1, RAB7, GARS, NFL, HSPB1, LMNA, FIG4, SH3TC2, DNM2, YARS, FGD4, NDRG1, TRPV4, HSPB8, MTMR2, SBF2 DNA Seq.)	B	8 mL L
<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, GDIAP1, RAB7, GARS, NFL, HSPB1, LMNA, FIG4, SH3TC2, DNM2, YARS, FGD4, NDRG1, TRPV4, HSPB8, MTMR2, SBF2 DNA Seq.	B	8 mL L
<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.	B	8 mL L
<input type="checkbox"/> 4003	CMT Advanced Evaluation - Dominant, Axonal* (MFN2, MPZ, RAB7, GARS, NFL, HSPB1, LMNA, DNM2, YARS, TRPV4, HSPB8)	B	8 mL L
<input type="checkbox"/> 4004	CMT Advanced Evaluation - Recessive, Demyelinating* (PRX, GDIAP1, SBF2, SH3TC2, MTMR2, NDRG1, FGD4, FIG4)	B	8 mL L
<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.	B	8 mL L
<input type="checkbox"/> 4006	CMT Advanced Evaluation - Recessive* (PRX, GDIAP1, SBF2, LMNA, FIG4, SH3TC2, MTMR2, NDRG1, FGD4)	B	8 mL L
<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, GDIAP1, DNM2, YARS, SH3TC2, MTMR2, NDRG1, FGD4, FIG4, SBF2 DNA Seq.	B	8 mL L

Test Code	Spec.	Vol.	Tube Type
<input type="checkbox"/> 4008	CMT Advanced Evaluation - Axonal* (MFN2, Cx32, MPZ, RAB7, GARS, NFL, HSPB1, GDIAP1, DNM2, YARS, LMNA, TRPV4, HSPB8)	B	8 mL L
Individual CMT Tests:			
<input type="checkbox"/> 144	TRPV4*	<input type="checkbox"/> 463	HSPB8*
<input type="checkbox"/> 354	MTMR2*	<input type="checkbox"/> 164	SBF2*
<input type="checkbox"/> 394	NDRG1*	<input type="checkbox"/> 208	FGD4*
<input type="checkbox"/> 253	DNM2*	<input type="checkbox"/> 468	YARS*
<input type="checkbox"/> 221	GDIAP1 (CMT2K, 4A)*	<input type="checkbox"/> 222	LITAF/SIMPLE (CMTIC)*
<input type="checkbox"/> 223	MFN2 (CMT2A2)*	<input type="checkbox"/> 239	PRX (CMT4F)*
<input type="checkbox"/> 247	PMP22 Seq.*	<input type="checkbox"/> 248	EGR2 (CMTID)*
<input type="checkbox"/> 249	NFL (CMT2E, 1F)*	<input type="checkbox"/> 131	PMP22 Dup./Del. (CMTIA)*
<input type="checkbox"/> 134	MPZ (CMT1B, 2I, 2J)*	<input type="checkbox"/> 226	LMNA (CMT2B1, 4CI)*
<input type="checkbox"/> 224	SH3TC2 (CMT4C)*	<input type="checkbox"/> 227	RAB7 (CMT2B)*
<input type="checkbox"/> 225	FIG4 (CMT4J)*	<input type="checkbox"/> 228	GARS (CMT2D)*
<input type="checkbox"/> 143	Cx32 Seq./Del. (CMTX)*	<input type="checkbox"/> 229	HSPB1 (CMT2F)*
<input type="checkbox"/> 243	Complete HNPP Evaluation* (PMP22 Sequencing, PMP22 Dup./Del.)	B	8 mL L
<input type="checkbox"/> 245	Congenital Hypomyelination Evaluation* (MPZ, EGR2)	B	8 mL L
<input type="checkbox"/> 296	Entrapment Neuropathy Evaluation* (PMP22 Seq., PMP22 Dup./Del., TTR)	B	8 mL L
<input type="checkbox"/> 235	TTR DNA Sequencing Test*	B	8 mL L
Peripheral Neuropathy: Hereditary Sensory Autonomic Neuropathy			
<input type="checkbox"/> 691	Early-Onset HSAN Evaluation* (NTRK1 and WNK1)	B	8 mL L
<input type="checkbox"/> 698	Late-Onset HSAN Evaluation* (SPTLC1 and SPTLC2)	B	8 mL L
<input type="checkbox"/> 551	SPTLC1 (HSAN I) DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 552	SPTLC2 (HSAN I) DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 553	WNK1 (HSAN II) DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 659	NTRK1 (HSAN IV) DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 660	ATL1 (HSAN I) DNA Sequencing Test*	B	8 mL L
<input type="checkbox"/> 719	SEPT9 (HNA) DNA Sequencing Test*	B	8 mL L

***Medicare ABN Required**

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 be indicated on the test requisition.

Specimen Type	Tube Type	
C - CSF	M - Muscle Tissue	P - Polypropylene CSF Transfer Tube
B - Blood		R - Red
S - Serum		L - Lavender
		C - Cryovial

** CSF must be collected in a tube not containing additives.

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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