Athena Diagnostics
International Endocrinology Test Requisition (October 2015)

athena diagnostics

Complete this requisition for all international samples. Athena requires that international specimens be accompanied by payment in U.S. dollars. If pre-payment is not received, there will be a delay in result reporting.

Please call our Client Services Department at 00-1-508-756-2886, extension 2 or contact us on our website at AthenaDiagnostics.com/international if you have questions regarding shipping or if you need further information.

Who Should Athena Contact with Questions About this Order?

Name_____
First Last

Phone_____ Fax_____

Email _____

Tests Ordered*

Check the test(s) required on the reverse **or** write in below.

Test Code_____ Test Name_____

Test Code_____ Test Name_____

Payment Information

☐ Bank Check Enclosed (made payable to Athena Diagnostcs, Inc.)

☐ Credit Card:

☐ Visa ☐ Discover ☐ MC ☐ AMEX

Credit Card #_____

Exp:_____Security Code:_____

Cardholder Name:_____
As it appears on card

Billing Address:

_____

_____

_____

☐ Wire Transfer (Athena will send you wire transfer details.)

Fax Number:_____

E-Mail:_____

Testing will not begin until payment is received.

Laboratory Information

Lab Name_____

Complete Lab Address:

_____

_____

_____

_____

_____

Phone_____ Fax_____

***Indicates required information**

Patient Identification

Patient Name*_____
First Last

DOB*_____ Sex: ☐ Male ☐ Female ☐ Unknown

Age*_____

Patient ID # (if available)_____

Authorization to Use De-Identified Sample or Data 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 or data 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

Name_____
First Last

Complete Mailing Address:

_____

_____

_____

_____

_____

Indications for Testing (Check One)

☐ Diagnostic (symptomatic) ☐ Clinical Study ☐ Prenatal

☐ Predictive (asymptomatic) ☐ Carrier ☐ Other Research

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 ☐ Muscle Date Collected*_____

Once this form is complete, please ensure that you have:

☐ **Verified the specimen type and included date of collection**

☐ **Verified that the Indications for Testing section has been completed by the physician**

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, patient ID no. These same two forms of ID should also be indicated on the test requisition.

200 Forest Street, 2nd Floor, Marlborough, MA 01752 • 00-1-508-756-2886 • Fax 00-1-774-843-3721 • AthenaDiagnostics.com

Athena Diagnostics Endocrinology Testing Services (October 2015)

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

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Test Code	Test Name	Genes Included
Adrenal Disorders		
☐ **816**	**Primary Adrenal Insufficiency (Addison's disease)**	ABCD1, NR0B1, AIRE
☐ 812	Autoimmune Polyglandular Syndrome (AIRE) DNA Sequencing Test	
☐ 815	ABCD1 DNA Sequencing Test (X-linked Adrenoleukodystrophy)	
☐ 814	NR0B1/DAX1 DNA Sequencing Test (X-linked Adrenal Hypoplasia Congenita)	
☐ 881	Endocrine Hypertension (HSD11B2) DNA Sequencing Test (Apparent Mineralocorticoid Excess)	
☐ 855	PHEX DNA Sequencing Test (X-linked Hypophosphatemic Rickets)	
☐ 856	FGF23 DNA Sequencing Test (Autosomal Dominant Hypophosphatemic Rickets)	
☐ **879**	**Congenital Adrenal Hyperplasia Evaluation** CYP21A2 sequencing and deletion, CYP11B1 sequencing	
☐ 880	CYP21A2 (CAH) DNA Sequencing and Deletion Test	
	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) DNA Sequencing Test	
Bone Diseases		
☐ **860**	**Osteogenesis Imperfecta Evaluation**	COL1A1, COL1A2
☐ 861	COL1A1 (OI) DNA Sequencing Test	
☐ 862	COL1A2 (OI) DNA Sequencing Test	
☐ 811	Osteoporosis-Pseudoglioma (LRP5) DNA Sequencing Test	
☐ 821	Idiopathic Osteoporosis (LRP5) 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 (CH) DNA Sequencing Test	
☐ 823	GCK (CH) DNA Sequencing Test	
☐ 826	KCNJ11 (CH) DNA Sequencing Test	
☐ 827	ABCC8 (CH) DNA Sequencing Test	
☐ **042**	**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) 4-Gene Evaluation**	GCK, HNF1A, HNF1B, HNF4A
☐ **8801**	**Monogenic Diabetes (MODY) 3-Gene Evaluation**	GCK, HNF1A, HNF1B
☐ **8802**	**Monogenic Diabetes (MODY) 2-Gene Evaluation**	GCK, HNF1A
☐ **885**	**Monogenic Diabetes (MODY) 5-Gene Evaluation**	HNF1A, GCK, HNF4A, HNF1B, IPF1
☐ 802	HNF4A (MODY1) DNA Sequencing and Deletion Test	
☐ 803	GCK (MODY2) DNA Sequencing and Deletion Test	
☐ 804	HNF1A (MODY3) DNA Sequencing and Deletion Test	
☐ 834	IPF1 (MODY4) DNA Sequencing Test	
☐ 805	HNF1B (MODY5) DNA Sequencing and Deletion Test	
☐ 837	CEL (MODY8) DNA Sequencing Test	
☐ **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	Nephrogenic Diabetes Insipidus (AQP2) DNA Sequencing Test	
Familial Cancer Syndromes		
☐ 818	MEN1 (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		
☐ **800**	**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 Panel**	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	

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

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		
☐ 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 (GHD) 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 (SS) 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 & Shipping Information (applies to all tests)

Specimen Type: Whole blood, 8 mL in yellow or lavender top (pediatric minimum volume: 2 mL)

Stability: Hemolysis may compromise DNA recovery and integrity after 48 hrs. It is recommended to ship samples immediately after draw. Samples can be stored for short periods only. Send specimen overnight at room temperature.

Shipping: Send specimen overnight at room temperature. If you have any questions on sample requirements or shipping, contact our client service department at 00-1-508-756-2886, extension 2.

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 6:30pm Eastern Time (U.S.).

International Customers please call

00-1-508-756-2886

or Fax 00-1-774-843-3721

athena diagnostics®

200 Forest Street, 2nd Floor
Marlborough, MA 01752 • AthenaDiagnostics.com

To: Whom it may concern

From:

CC:

Date:

Re: International Blood Sample

Please be advised that:

The items contained in this shipment under Air bill number_____ are samples of whole human blood from a patient in plastic specimen collector tubes that will be used for Laboratory testing only.

The specimen collection tubes in the shipment are of "Human material containing no animal material "or" Non-human primate material or other non-primate animal material.

We hereby declare that the human blood samples from a patient contained in this shipment under Air bill number _____"are not of tissue culture origin or any imported material that is a human vaccine in final dosage form.

We also so state that the samples contained in this shipment under Air bill number _____, are non-cultured, non-recombinant, non-infectious, containing no animal content and/or bovine serum albumin.

We also declare that the human blood samples from a patient contained in this package under Air bill number _____, have not had any previous testing.

The sample is being sent to Athena Diagnostics, Inc., the only clinical reference laboratory dedicated exclusively to testing for certain neurological disorders, their mission extends to providing diagnostic results that encompass interpretation, counseling and educational resources for healthcare professional and the patients for whom they care.

If the above advisories do not meet with the protocol standards, please advise. The telephone number

is _____.

Sincerely,

_____