

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

Please call our Client Services Department at 00-1-508-756-2886, option 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 Diagnostics, 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 CVS: Cultured Amniotic Fluid: Cultured DNA** Date Collected* _____

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

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.

Athena Diagnostics Endocrinology Testing Services (March 2018)

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



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	HNFI1A, GCK, HNF4A, HNF1B
<input type="checkbox"/> 8801	Monogenic Diabetes (MODY) Three-Gene Evaluation	HNFI1A, GCK, HNF1B
<input type="checkbox"/> 8802	Monogenic Diabetes (MODY) Two-Gene Evaluation	HNFI1A, GCK
<input type="checkbox"/> 885	Monogenic Diabetes (MODY) Five-Gene Evaluation	HNFI1A, 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	

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		
<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, KISSIR
<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	GnRHI DNA Sequencing Test	
<input type="checkbox"/> 358	TACR3 DNA Sequencing Test	
<input type="checkbox"/> 364	KISSIR 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, GnRHI, KISSIR, TACR3
<input type="checkbox"/> 667	Normosmic Kallmann/IHH Evaluation	PROK2, PROKR2, FGF8, FGFR1, GnRHR, GnRHI, TACR3, KISSIR

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 & 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 9:00pm Eastern Time (U.S.).

International Customers please call
00-1-508-756-2886
 or Fax 00-1-774-843-3721



200 Forest Street, 2nd Floor
 Marlborough, MA 01752 USA • 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" Nonhuman 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,
