Athena Diagnostics Neurology Patient Insurance Test Requisition (September 2017)

Patients Requesting Financial Assistance – Patients who meet certain income guidelines may qualify for financial assistance. Please complete the patient identification information and Athena Diagnostics® will contact the patient directly to initiate the application process and (for patients where insurance remits to patient only) to collect prepayment.

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

Please tear at perforation

Patient

Insured Patient Information

Complete this requisition for all patients with insurance, including Medicare. Patients with an insurance plan for which Athena Diagnostics is a contracted provider are subject to any co-insurance and deductible of their plan. Athena Diagnostics will bill the patient's insurance for the total price of the test and work on the patient's behalf to file appropriate justifications and/or appeals when applicable. Patients should verify coverage with their health plan prior to testing.

Patient Identification

Patient Name _____ (First) _____ (Last)

Patient ID # (if available) _____

DOB _____ Sex: ☐ Male ☐ Female ☐ Unknown

Mailing Address _____

_____

City _____ State _____ Zip _____

Phone #1 _____ ☐ Day ☐ Eve ☐ Cell

Phone #2 _____ ☐ Day ☐ Eve ☐ Cell

Patient E-mail: _____

Appeal Authorization: In the event of an underpayment or denial by my insurance carrier, I hereby authorize Athena Diagnostics or their designee to appeal to my insurance carrier on my behalf,[1] to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. This authorization shall remain valid until the charges for the orders on this form are paid in full.

Authorization to Release Information and Pay Benefits: I authorize Athena Diagnostics to provide my insurance carrier all information, including test results, concerning my laboratory test(s). I understand that I may be responsible for all charges not covered by my insurance carrier, and I understand that payment is due within thirty (30) days of receipt of your invoice. I authorize and direct that benefits under this claim be paid directly to Athena Diagnostics, and I agree to remit to Athena Diagnostics immediately any payment for these services made directly to me. I acknowledge that the charges for the test(s) ordered by my physician will be withdrawn in the event of cancellation only if such cancellation is executed by the ordering physician and a copy of the written confirmation evidencing this action is provided to Athena prior to the issuance of the test result.

1. Athena Diagnostics and/or designee may perform this appeal on my behalf, but is not obligated to do so.

STOP Signature Required Here

_____

Patient Signature Date

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

Patient Insurance Information

Please provide a photocopy of the front and back of the insurance card.

Name of Insured _____ (First) _____ (Last)

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Insurance Co. Name _____

Member ID # _____

Group ID # _____

Address _____

City _____ State _____ Zip _____

Phone _____

Does the patient have secondary insurance? ☐ Yes ☐ No

If yes, please attach face sheet and copy of front and back of insurance card.

Physician

Physician/Laboratory Contact Information

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 also be indicated on the test requisition.

Contact Name _____ (First) _____ (Last)

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): _____

Required Physician Information

NPI # _____

Athena Account # (if assigned) _____

Name _____ (First) _____ (Last)

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

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.

Additional Authorized Result Report Recipient

Name _____ (First) _____ (Last)

UPIN # or CLIA # _____

Address _____ (P.O. Box not acceptable)

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Indications for Genetic Testing (Check One)

☐ Diagnostic (symptomatic) ☐ Prenatal ☐ Family Testing

☐ Predictive (asymptomatic) ☐ Carrier

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.

For Specimen Collection Service,* Please Fax this Test Requisition to 610-271-6085.

* Specimen collection service will work with the patient to obtain phlebotomy services through either a home draw or other laboratory. See online catalog at AthenaDiagnostics.com for complete test specifications and shipping information. 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 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		Pref. Spec.	Pref. Vol.	Tube Type
Cerebrovascular Disease (Stroke)				
☐ 1175	Notch3(CADASIL) Sequencing Test	B	8 mL	L
☐ 1149	HTRA1 (CARASIL) Sequencing Test*	B	8 mL	L
☐ 1120	COL4A1 Sequencing Test* (CSVD)	B	8 mL	L
☐ **1122**	**Complete CCM Sequencing and CNV Evaluation*** (KRIT1 Seq./Del., CCM2 Seq./Del., PDCD10 Seq./Del.)	B	8 mL	L
☐ **1152**	**KRIT1 (CCM1) Seq. and CNV Evaluation***	B	8 mL	L
☐ **1106**	**CCM2 Seq. and CNV Evaluation***	B	8 mL	L
☐ **1179**	**PDCD10 (CCM3) Seq. and CNV Evaluation***	B	8 mL	L
Dementia				
☐ **178**	**ADmark® Alzheimer's Evaluation*** (ApoE, Phospho-Tau, Total-Tau, Aß42) (Symptomatic for Dementia) (CSF must be in polypropylene tube and arrive on cold pack or frozen)	C B	2 mL 8 mL	P L
☐ 109	ADmark® ApoE Genotype Analysis & Interpretation* (Symptomatic for Dementia)	B	8 mL	L
☐ 177	ADmark® Phospho-Tau/Total-Tau/Aß42 CSF Analysis & Interpretation (Symptomatic) (CSF must be in polypropylene tube and arrive on cold pack or frozen)	C	2 mL	P
☐ **179**	**ADmark® Early-Onset Alzheimer's Evaluation*** (PS-1, APP Seq./Dup., PS-2)	B	8 mL	L
☐ 167	ADmark® PSEN1 DNA Sequencing Test*	B	8 mL	L
☐ 168	ADmark® APP DNA Sequencing Test and Duplication Test *	B	8 mL	L
☐ 169	ADmark® PSEN2 DNA Sequencing Test*	B	8 mL	L
☐ **281**	**Frontotemporal Dementia (FTD) Evaluation*** (MAPT, GRN, C9orf72)	B	8 mL	L
☐ 209	C9orf72 (FTD) DNA Test*	B	8 mL	L
☐ 204	GRN DNA Sequencing Test*	B	8 mL	L
☐ 205	MAPT DNA Sequencing Test*	B	8 mL	L
☐ **1711**	**Autoimmune Rapidly Progressive Dementia Evaluation with Recombx®** (Hu, MaTa, CV2, Amphiphysin, GAD65, NMDA, VGKC, LGI1, CASPR2)	S	2 mL	R
☐ 1714	Recombx® Hu Autoantibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL	R
☐ 1716	Recombx® MaTa Autoantibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL	R
☐ 1717	Recombx® CV2 Autoantibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL	R
☐ 1718	Recombx® Amphiphysin Autoantibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL	R
☐ 1705	GAD65 Antibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL	R
☐ 1706	NMDA Receptor Antibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL	R
☐ 1707	VGKC Antibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL	R
☐ 1708	LGI1 Antibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL	R
☐ 1709	CASPR2 Antibody Test (Autoimmune Rapidly Progressive Dementia)	S	2 mL	R
Developmental Disabilities				
☐ **1186**	**Primary Microcephaly Sequencing Evaluation*** (ASPM, MCPH1, WDR62)	B	8 mL	L
☐ 1092	ASPM Sequencing Test*	B	8 mL	L
☐ 1153	MCPH1 Sequencing Test*	B	8 mL	L
☐ 1257	WDR62 Sequencing Test*	B	8 mL	L
☐ 1193	SHANK3 Sequencing Test*	B	8 mL	L
☐ 1192	SHANK2 Sequencing Test*	B	8 mL	L
☐ 1190	PTEN Sequencing Test*	B	5 mL	L
☐ **795**	**Joubert Syndrome Evaluation*** (TMEM67, TMEM216, AHI1, CEP290, NPHP1, CC2D2A)	B	8 mL	L
☐ 792	TMEM67 DNA Sequencing Test*	B	8 mL	L
☐ 789	TMEM216 DNA Sequencing Test*	B	8 mL	L
☐ 790	AHI1 DNA Sequencing Test*	B	8 mL	L
☐ 791	CEP290 DNA Sequencing Test*	B	8 mL	L
☐ 793	NPHP1 DNA Deletion Test*	B	8 mL	L
☐ 794	CC2D2A DNA Sequencing Test*	B	8 mL	L
☐ 737	Smith-Lemli-Opitz Syndrome (DHCR7) DNA Test*	B	8 mL	L
☐ 1256	VPS13B (COH1) Sequencing Test*	B	8 mL	L
☐ **1155**	**MECP2 Sequencing and CNV Evaluation***	B	8 mL	L
☐ 148	Rett Syndrome (MECP2) Dup./Del. Test*	B	8 mL	L
☐ **1038**	**ARX Seq. and CNV Evaluation (Intellectual Disability)***	B	8 mL	L
☐ **1114**	**CDKL5 Seq. and CNV Evaluation (Atypical Rett)***	B	8 mL	L
☐ 1194	SYNGAP1 Sequencing Test*	B	8 mL	L
☐ **1166**	**MEF2C Sequencing and CNV Evaluation***	B	4 mL	L
☐ **1142**	**FOXG1 Sequencing and CNV Evaluation***	B	4 mL	L
NOTE: Pediatric minimum for all Developmental Disabilities tests is 2 mL.				
Epilepsy				
☐ **6000**	**Epilepsy Advanced Sequencing and CNV Evaluation***	B	8 mL	L
☐ **6008**	**Epilepsy Advanced Sequencing and CNV Evaluation - Generalized, Absence, Focal, Febrile and Myoclonic Epilepsies***	B	8 mL	L
☐ **6010**	**Epilepsy Advanced Sequencing and CNV Evaluation - Epileptic Encephalopathy***	B	8 mL	L
☐ **6018**	**Epilepsy Advanced Sequencing and CNV Evaluation - Developmental Brain Malformations***	B	8 mL	L
☐ **6019**	**Epilepsy Advance Sequencing and CNV Evaluation - Intellectual Disability***	B	8 mL	L
☐ **6022**	**Epilepsy Advanced Sequencing and CNV Evaluation - Neuronal Ceroid Lipofuscinosis***	B	8 mL	L
☐ **6023**	**Epilepsy Advanced Sequencing and CNV Evaluation - Epilepsy with Migraine***	B	8 mL	L
☐ **6033**	**Epilepsy Advanced Sequencing and CNV Evaluation - Syndromic Disorders***	B	8 mL	L
☐ **6038**	**Epilepsy Advanced Sequencing and CNV Evaluation - Infantile Spasms***	B	8 mL	L
Please see website for the list of genes in each panel.				
☐ **5120**	**Autoimmune Epilepsy Evaluation** GAD65, VGKC, CASPR2, LGI1, NMDA	S	2 mL	R
☐ 5101	GAD65 Neurological Syndrome Antibody Test (Epilepsy) (Single)	S	2 mL	R
☐ 5102	VGKC Antibody Test (Epilepsy) (Single)	S	2 mL	R
☐ 5103	CASPR2 Antibody Test (Epilepsy) (Single)	S	2 mL	R
☐ 5104	LGI1 Antibody Test (Epilepsy) (Single)	S	2 mL	R
☐ 5105	NMDA Receptor (NR1-subunit) Antibody Test (Epilepsy) (Single)	S	2 mL	R
☐ **1131**	**Complete Tuberous Sclerosis Seq. * and CNV Evaluation*** (TSC1 Seq., TSC1 Del., TSC2 Seq., TSC2 Del.)	B	8 mL	L
☐ 1245	TSC1 Sequencing Test*	B	8 mL	L
☐ 1236	TSC1 CNV Test*	B	8 mL	L
☐ 508	TSC1 Deletion Analysis	B	8 mL	L
☐ 1255	TSC2 Sequencing Test*	B	8 mL	L
☐ 1254	TSC2 CNV Test*	B	8 mL	L
☐ 524	TSC2 DNA Deletion Test	B	8 mL	L
☐ 523	TSC Familial DNA Seq. Mutation Evaluation*	B	8 mL	L
	Proband Accession # _____			
	Relationship _____			
☐ **1129**	**SCN1A Seq. and CNV Evaluation***	B	8 mL	L
☐ 1191	SCN1A CNV Test*	B	8 mL	L
☐ 537	SCN1A Deletion Test	B	8 mL	L
☐ **1133**	**CSTB (EPM1) Seq. and Repeat Expansion Evaluation***	B	8 mL	L
☐ 410	EPM1 DNA Test*	B	8 mL	L
☐ **1036**	**ARX Seq. and CNV Evaluation (Epilepsy)***	B	8 mL	L
☐ **1115**	**CDKL5 Seq. and CNV Evaluation (Epilepsy)***	B	8 mL	L
☐ 4411	SLC2A1 DNA Sequencing Test	B	8 mL	L
☐ 1003	GFAP (Alexander Disease) Seq. Test*	B	8 mL	L
☐ 443	POLG DNA Seq. Test* (Alpers Syndrome)	B	8 mL	L
NOTE: Pediatric minimum for all Epilepsy tests is 2 mL.				
Family Testing				
☐ 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				
☐ **329**	**Connexin Related Deafness Evaluation*** (Connexin 26, Connexin 30)	B	8 mL	L
☐ 321	Connexin 26 (GJB2) DNA Sequencing Test*	B	8 mL	L
☐ 319	Connexin 30 (GJB6) DNA Test*	B	8 mL	L
Leukodystrophy				
☐ 1175	Notch3(CADASIL) Sequencing Test*	B	8 mL	L
☐ **6106**	**Leukoencephalopathy with Vanishing White Matter Evaluation*** (EIF2B1, EIF2B2, EIF2B3, EIF2B4, EIF2B5)	B	8 mL	L
☐ 6101	EIF2B1 DNA Sequencing Test*	B	8 mL	L
☐ 6102	EIF2B2 DNA Sequencing Test*	B	8 mL	L
☐ 6103	EIF2B3 DNA Sequencing Test*	B	8 mL	L
☐ 6104	EIF2B4 DNA Sequencing Test*	B	8 mL	L
☐ 6105	EIF2B5 DNA Sequencing Test*	B	8 mL	L
☐ 6107	ARSA DNA Sequencing Test*	B	8 mL	L
☐ 6108	ABCD1 DNA Sequencing Test*	B	8 mL	L
☐ **1183**	**PLP1 Sequencing and CNV Evaluation***	B	8 mL	L
☐ 6109	GJC2 DNA Sequencing Test*	B	8 mL	L
Migraine				
☐ **1148**	**Hemiplegic Migraine Seq. Evaluation*** (CACNA1A, ATP1A2, SCN1A)	B	8 mL	L
☐ 1103	CACNA1A Sequencing Test*	B	8 mL	L
☐ 1101	ATP1A2 Sequencing Test*	B	8 mL	L
☐ 1136	SCN1A Sequencing Test (FHM)* (Exons 3, 23, 26)	B	8 mL	L
Mitochondrial Disorders				
☐ **575**	**Common Mitochondrial Disorders Evaluation*** (POLG, MELAS, MERRF, NARP)	B	8 mL	L
☐ **576**	**Progressive External Ophthalmoplegia Evaluation*** (POLG, TWINKLE, ANT1, OPA1, MELAS)	B	8 mL	L
☐ **577**	**Mitochondrial Neurogastrointestinal Encephalopathy (MNGIE) Evaluation*** (TYMP, RRM2B, MELAS)	B	8 mL	L
☐ **578**	**Mitochondrial Hepatoencephalopathic Evaluation*** (POLG, DGUOK, MPV17, TWINKLE)	B	8 mL	L
☐ **579**	**Mitochondrial Encephalomyopathic Evaluation*** (TK2, RRM2B, POLG)	B	8 mL	L
☐ **515**	**LHON mtDNA Evaluation*** (LHON 11778, 3460, 14484)	B	8 mL	L
☐ 474	POLG DNA Sequencing Test* (Related to all allelic disorders)	B	8 mL	L
☐ 479	TWINKLE (PEO1/C10orf2) DNA Seq. Test* (Related to mtDNA depletion)	B	8 mL	L
☐ 466	ANT1 (SLC25A4) DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL	L
☐ 469	OPA1 DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL	L
☐ 484	TYMP DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL	L
☐ 486	RRM2B DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL	L

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

***Medicare ABN Required**

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

athena diagnostics

Test Code		Pref. Spec.	Pref. Vol.	Tube Type
☐ 487	DGUOK DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL	L
☐ 488	MPV17 DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL	L
☐ 489	TK2 DNA Sequencing Test* (Related to mtDNA depletion)	B	8 mL	L
☐ 517	MELAS mtDNA Evaluation* (MELAS 3243, 3271, 3252, 3256, 3291, 13513)	B	8 mL	L
☐ 518	MERRF mtDNA Evaluation* (MERRF 8344, 8356, 8296, 8363)	B	8 mL	L
☐ 516	NARP mtDNA Evaluation* (NARP 8993)	B	8 mL	L
☐ 824	PDHA1 DNA Sequencing Test*	B	8 mL	L
Motor Neuron Diseases				
☐ **6520**	**Amyotrophic Lateral Sclerosis Advanced Evaluation*** (ALS2, ANG, CHMPB2, C9ORF72, DCTN1, FIG4, FUS, OPTN, PFN1, SETX, SIGMAR1, SOD1, SQSTM1, TARDBP, UBQLN2, VAPB, VCP)	B	8mL	L
☐ **6522**	**Nonprevalent Amyotrophic Lateral Sclerosis Advanced Sequencing Evaluation*** (ALS2, ANG, CHMPB2, DCTN1, FIG4, FUS, OPTN, PFN1, SETX, SIGMAR1, SQSTM1, TARDBP, UBQLN2, VAPB, VCP)	B	8mL	L
☐ 670	C9orf72 DNA Test*	B	8 mL	L
☐ 620	SOD1 DNA Sequencing Test*	B	8 mL	L
☐ **6601**	**HSP, Common Sporadic Evaluation*** (SPAST, SPG7)	B	8 mL	L
☐ **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, L1CAM, PLP1)	B	8 mL	L
☐ **6610**	**HSP, Complete Dominant Evaluation*** (SPAST, ATLN, REEP1, KIF5A, NIPA1, KIAA0196, BSCL2, HSPD1, RTN2, SLC33A1)	B	8 mL	L
☐ **6611**	**HSP, Common Dominant Evaluation*** (SPAST, ATLN, REEP1, KIF5A)	B	8 mL	L
☐ **6612**	**HSP, Supplemental Dominant Evaluation*** (NIPA1, KIAA0196, BSCL2, HSPD1, RTN2, SLC33A1)	B	8 mL	L
☐ **6620**	**HSP, Complete Recessive Evaluation*** (SPG11, ZFYVE26, SPG7, CYP7B1, ALS2, AP5Z1, FA2H, KIF1A, PNPLA6, SACS, SPG20, SPG21)	B	8 mL	L
☐ **6621**	**HSP, Common Recessive Evaluation*** (SPG11, ZFYVE26, SPG7)	B	8 mL	L
☐ **6622**	**HSP, Supplemental Recessive Evaluation*** (CYP7B1, ALS2, AP5Z1, FA2H, KIF1A, PNPLA6, SACS, SPG20, SPG21)	B	8 mL	L
☐ **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, L1CAM, PLP1)	B	8 mL	L
☐ **6631**	**HSP, X-Linked Evaluation*** (L1CAM, PLP1)	B	8 mL	L
☐ **6509**	**SPG4 Evaluation***	B	8 mL	L
Individual HSP DNA Tests: ☐ 531 Atlastin (SPG3A)* ☐ 633 Spatacsin (SPG11)* ☐ 632 Paraplegin (SPG7)* ☐ 614 ZFYVE26 (SPG15)*		B	8 mL	L
☐ **214**	**SMA Plus** (Reflexive)* Testing is performed in this order: 1. SMN1 Del./SMN2 Del.; 2. SMN1 Seq.	B	4 mL	L
☐ 111	SMA Diagnostic Test (including SMN2 Copy Number)	B	4 mL	L
☐ 211	SMN DNA Sequencing Test* (only order if deletion testing has already been performed)	B	4 mL	L
☐ 444	SMA Carrier Screen SMN1 Del./SMN2 Del. Test*	B	4 mL	L
☐ 117	Kennedy's Disease (SBMA) DNA Test*	B	8 mL	L
☐ **6521**	**Atypical Spinal Muscular Atrophy Advanced Sequencing Evaluation*** (BICD2, DYNC1H1, GARS, HSPB1, HSPB3, HSPB8, IGHMBP2, TRPV4, UBA1, VRK1)	B	8 mL	L
Movement Disorders				
☐ **6900**	**Ataxia, Complete Dominant Evaluation** (ATXN1, ATXN2, ATXN3, CACNA1A, ATXN7, TBP, ATXN8OS, ATXN10, PPP2R2B, ATN1, AFG3L2, KCNC3, PRKCG, SPTBN2, EEF2, FGF14, ITPR1, KCND3, PDYN, TGM6, TTBK2, VAMP1, KCNA1, CACNB4, SLC1A3, CACNA1A)	B	10 mL	L
☐ **6901**	**Ataxia, Common Repeat Expansion Evaluation** (ATXN1, ATXN2, ATXN3, CACNA1A, ATXN7, TBP, ATXN8OS, ATXN10)	B	8 mL	L
☐ **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
☐ **6910**	**Ataxia, Complete Recessive Evaluation** (FXN, APTX, ATM, SETX, TTPA, ADCK3, AFG3L2, ANO10, FLVCR1, GRM1, MRE11A, MTPAP, SACS, SYNE1, SYT14, TDP1, SIL1, POLG)	B	8 mL	L
☐ **6911**	**Ataxia, Supplemental Recessive Evaluation** (APTX, ATM, SETX, TTPA, ADCK3, AFG3L2, ANO10, FLVCR1, GRM1, MRE11A, MTPAP, SACS, SYNE1, SYT14, TDP1, SIL1, POLG)	B	8 mL	L
☐ **6912**	**Oculomotor Apraxia Ataxia Advanced Sequencing Evaluation** (APTX, SETX)	B	8 mL	L
☐ **6920**	**Episodic Ataxia Evaluation** (CACNB4, KCNA1, SLC1A3, CACNA1A)	B	8 mL	L
☐ **6930**	**Ataxia, Comprehensive Evaluation** (ATXN1, ATXN2, ATXN3, CACNA1A, ATXN7, TBP, ATXN8OS, ATXN10, PPP2R2B, ATN1, AFG3L2, KCNC3, PRKCG, SPTBN2, EEF2, FGF14, ITPR1, KCND3, PDYN, TGM6, TTBK2, VAMP1, KCNA1, CACNB4, SLC1A3, CACNA1A, FXN, APTX, ATM, SETX, TTPA, ADCK3, AFG3L2, ANO10, FLVCR1, GRM1, MRE11A, MTPAP, SACS, SYNE1, SYT14, TDP1, SIL1, POLG)	B	10 mL	L
☐ **349**	**Ataxia, Friedreich (FXN) Evaluation*** (FRDA/FXN Seq., FRDA/FXN Expansion)	B	8 mL	L
☐ **353**	**Ataxia-Telangiectasia (ATM) Evaluation*** (ATM Seq., ATM Dup./Del.)	B	8 mL	L
Individual Ataxia DNA Tests: ☐ 371 SCA1* ☐ 373 SCA6* ☐ 387 SCA10* ☐ 401 DRPLA* ☐ 283 TTPA (AVED)* ☐ 119 FRDA/FXN Expansion* ☐ 672 SCA2* ☐ 677 SCA7* ☐ 285 SCA12* ☐ 383 POLG1 (MIRAS)* ☐ 348 FRDA/FXN Seq.* ☐ 105 SCA3* ☐ 384 SCA8* ☐ 388 SCA17*		B	8 mL	L
☐ **402**	**Chorea Differential Evaluation*** (DRPLA, HD)	B	8 mL	L
☐ 116	Huntington Disease Repeat Expansion Test*	B	8 mL	L
☐ **639**	**Isolated Dystonia Evaluation*** (DYT1, THAP1)	B	8 mL	L
☐ 626	Dystonia (DYT1) DNA Test*	B	8 mL	L
☐ 618	THAP1 DNA Sequencing Test* (DYT6)	B	8 mL	L
☐ **629**	**Complete Dopa-Responsive Dystonia (DYT5) Evaluation*** (GCH1 Seq., GCH1 Del., TH Seq.)	B	8 mL	L
☐ 637	GCH1 DNA Sequencing Test* (DYT5A)	B	8 mL	L
☐ 638	GCH1 Deletion Test (DYT5A)*	B	8 mL	L
☐ 634	TH DNA Sequencing Test (DYT5B)*	B	8 mL	L
☐ 624	SGCE DNA Sequencing Test (DYT11)*	B	8 mL	L
☐ 627	SGCE Deletion Test (DYT11)*	B	8 mL	L
☐ 617	PNKD (MR-1) DNA Sequencing Test*	B	8 mL	L
☐ **588**	**Complete Parkinsonism Evaluation*** (LRRK2, PARK2, PINK1, PARK7, SNCA)	B	8 mL	L
☐ 558	LRRK2 DNA Sequencing Test*	B	8 mL	L
☐ 559	PARK2 (Parkin) DNA Sequencing Test*	B	8 mL	L
☐ 040	PARK2 (Parkin) Duplication/Deletion Test*	B	8 mL	L
☐ 542	PINK1 DNA Sequencing Test*	B	8 mL	L
☐ 058	PINK1 Deletion Test*	B	8 mL	L
☐ 554	PARK7 (DJ1) DNA Sequencing Test*	B	8 mL	L
☐ 047	PARK7 (DJ1) Deletion Test*	B	8 mL	L
☐ 557	Alpha Synuclein (SNCA) DNA Seq. Test*	B	8 mL	L
☐ 059	Alpha Synuclein (SNCA) Dup./Del. Test*	B	8 mL	L
☐ 1187	PRRT2 (Dyskinesia/IC) Seq. Test*	B	8 mL	L
Multiple Sclerosis				
☐ 112	NAbFeron® (INFB-1) Neutralizing Antibody Test	S	2 mL	R
☐ 197	TYSABRI® (Natalizumab) Antibody Test (See website for collection notes)	S	2 mL	R
☐ 193	AQP4 (NMO-IgG) Antibody Test	S	8 mL	R
Myasthenia Gravis				
☐ 482	MuSK Antibody Test	S	2 mL	R
☐ 1480	Titin Antibody Test	S	2 mL	R
☐ 1481	RyR Autoantibody Test	S	2 mL	R
☐ 1483	LRP4 Autoantibody Test	S	2 mL	R
☐ 1490	AChR-Seronegative Myasthenia Gravis Evaluation	S	2 mL	R
☐ 1510	Acetylcholine Receptor Binding Antibody with Reflex to Musk Antibody	S	2mL	R
☐ 1511	Acetylcholine Receptor Binding Antibody with Reflex to MuSK/LRP4 Antibodies	S	2 mL	R
☐ 1513	Acetylcholine Receptor Binding Antibody	S	2 mL	R
☐ 1514	Myasthenia Gravis Panel 2	S	2 mL	R
☐ 1516	Acetylcholine Receptor Blocking Antibody	S	1 mL	R
☐ 1517	Acetylcholine Receptor Modulating Antibody	S	1mL	R
☐ 1521	Myasthenia Gravis Panel 2 with Reflex to MuSK Antibody	S	3mL	R
Neuromuscular Disorders				
☐ **5501**	**Muscular Dystrophy Advanced Evaluation**	B	8 mL	L
☐ **5502**	**Congenital Muscular Dystrophy Advanced Sequencing Evaluation**	B	8 mL	L
☐ **5503**	**Congenital Myopathy Advanced Sequencing Evaluation**	B	8 mL	L
☐ **5504**	**Distal Myopathy Advanced Sequencing Evaluation**	B	8 mL	L
☐ **5505**	**Myofibrillar Myopathy Advanced Sequencing Evaluation**	B	8 mL	L
☐ **5506**	**Myotonic Syndromes Advanced Sequencing Evaluation**	B	8 mL	L
☐ **5507**	**Periodic Paralysis Advanced Sequencing Evaluation**	B	8 mL	L
☐ **5508**	**Malignant Hyperthermia Advanced Sequencing Evaluation**	B	8 mL	L
☐ **5518**	**Emery-Dreifuss Muscular Dystrophy Advanced Sequencing Evaluation**	B	8 mL	L
☐ **5519**	**Limb Girdle Muscular Dystrophy Advanced Evaluation**	B	8 mL	L
☐ **5511**	**Congenital Myasthenic Syndrome Advanced Sequencing Evaluation**	B	8 mL	L
☐ **5530**	**DMD Evaluation**	B	8 mL	L
NOTE: Please see website for the list of genes in each panel.				
☐ 5531	DMD Duplication/Deletion	B	8 mL	L
☐ 183	DMD DNA Sequencing Test*	B	8 mL	L
☐ 100	Dystrophin ProteinTest	M	10 mg	C
☐ **207**	**Early-Onset Myotonia Evaluation*** (DM1, CLCN1, SCN4A)	B	8 mL	L
☐ 108	DMPK DNA Test (DM1)*	B	8 mL	L
☐ 110	CNBP DNA Test (DM2)* (DM2 testing is not recommended for patients with early onset myotonic dystrophy)			
☐ 128	CLCN1 DNA Sequencing Test*			
☐ 146	SCN4A (Myotonia) DNA Sequencing Test*			
☐ **585**	**CAPN3 Evaluation*** (includes CAPN3 Seq., CAPN3 Del.)	B	8 mL	L
Individual Limb Girdle Muscular Dystrophy Tests: ☐ 562 FKRP* ☐ 565 LMNA* ☐ 566 CAV3* ☐ 582 SGCA Duplication/Deletion Test* ☐ 583 SGCG Duplication/Deletion Test* ☐ 584 CAPN3 Duplication/Deletion Test*		B	8 mL	L
☐ 561	Dysferlin Protein Blood Test* (must arrive on cold pack) Sample must be received within 72 hours of draw.	B	10 mL	L
☐ 571	Dysferlin Sequencing Test* Sample must be received within 72 hours of draw.	B	8 mL	L
☐ 405	FSHD1 Southern Blot Test* Sample must be received within 72 hours of draw.	B	15 mL	L
☐ 5905	FSHD Molecular Combing Test* Sample must be received within 72 hours of draw.	B	15 mL	L
☐ 300	OPMD Repeat Expansion Test*	B	8 mL	L
☐ **490**	**Optic Atrophy Evaluation*** (OPA1)	B	8 mL	L
Neuro-Oncology				
☐ **648**	**Neurofibromatosis Type 1 (NF1) Evaluation*** (NF1 Sequencing, NF1 Deletion)	B	8 mL	L
☐ **645**	**Neurofibromatosis Type 2 (NF2) Evaluation*** (NF2 Seq., NF2 Dup./Del.)	B	8 mL	L
☐ 646	Neurofibromatosis Type 1 DNA Sequencing Test*	B	8 mL	L
☐ 647	Neurofibromatosis Type 1 Deletion Test*	B	8 mL	L
☐ 635	Neurofibromatosis Type 2 DNA Sequencing Test*	B	8 mL	L
☐ 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				
☐ **4711**	**Paraneoplastic Neurological Syndromes Evaluation with Recombx®, Initial Assessment** (Hu, Yo, CV2, MaTa, Ri, Amphiphysin)	S C	2 mL or 2 mL	R P**
☐ **4620**	**NeoComplete Paraneoplastic Evaluation with Recombx®** Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, VGCC, VGKC, Amphiphysin, gnAChR, NMDA, GAD65, LGI1, CASPR2.	S	2 mL	R
☐ **4640**	**Paraneoplastic Autoantibody Evaluation with Recombx®, CSF** Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, Amphiphysin, NMDA, LGI1, CASPR2.	C	2ml	P**
☐ **4724**	**NeoCerebellar Degeneration Paraneoplastic Profile with Recombx®** (Hu, Yo, Zic4, CV2, MaTa, Ri, Amphiphysin, GAD65 Neurological Syndrome)	S	2 mL	R
☐ **4722**	**NeoEncephalitis Paraneoplastic Evaluation with Recombx®** (Hu, CV2, MaTa, VGKC, Amphiphysin, GAD65, LGI1, NMDA, CASPR2)	S	2 mL	R
☐ **4725**	**NeoSensory Neuropathy Paraneoplastic Profile with Recombx®** (Hu, CV2, Amphiphysin)	S	2 mL	R
☐ **4727**	**Neuromyotonia Evaluation** (CASPR2, VGKC)	S	2 mL	R
Individual Recombx® Autoantibody Tests: ☐ 4684 CAR ☐ 4681 CV2 ☐ 4682 Hu ☐ 4683 MaTa ☐ 4685 Ri ☐ 4686 Yo ☐ 4689 Zic4		S	2 mL	R

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

*Medicare ABN Required

Test Code		Pref. Spec.	Pref. Vol.	Tube Type
☐ 449	LGI1 Antibody Test	S	2 mL	R
☐ 499	CASPR2 Antibody Test	S	2 mL	R
☐ 419	NMDA Receptor (NR1-subunit) Antibody Test	S	2 mL	R
☐ 422	GAD65 Neurological Syndrome Antibody Test	S	2 mL	R
☐ 475	LEMS (VGCC) Antibody Test	S	2 mL	R
☐ 485	VGKC Antibody Test	S	2 mL	R
☐ 4674	Recombx® Amphiphysin Autoantibody Test	S	2 mL	R
☐ 428	Ganglionic AChR Antibody Test	S	2 mL	R
Peripheral Neuropathy: Autoimmune				
☐ **3100**	**SensoriMotor Neuropathy Profile with Recombx® - Complete** (Co-GM1 Quattro®, MAG 'Dual Antigen'®, Hu, GALOP™, SGPG, Sulfatide)	S	2 mL	R
☐ **3148**	**Sensory Neuropathy Profile with Recombx®** (MAG 'Dual Antigen'®, Hu, GALOP™, SGPG, Sulfatide)	S	2 mL	R
☐ **3163**	**Motor Neuropathy Profile - Complete** (Co-GM1 Quattro®, SGPG, MAG 'Dual Antigen'®)	S	2 mL	R
☐ **289**	**Multifocal Motor Neuropathy Evaluation*** (Co-GM1 Quattro®, PMP22 Dup./Del.)	S B	2 mL 8 mL	R L
☐ 3155	Co-GM1 Quattro® Autoantibody Test	S	2 mL	R
☐ 3127	MAG 'Dual Antigen'® Autoantibody Test	S	2 mL	R
☐ 261	GALOP™ Antibody Test	S	2 mL	R
☐ 210	Sulfatide Antibody Test	S	2 mL	R
☐ 160	GQ1b Antibody Test	S	2 mL	R
☐ 278	GD1a Antibody Test	S	2 mL	R
☐ 272	Co-Asialo Antibody Test	S	2 mL	R
☐ 273	Co-GD1b Antibody Test	S	2 mL	R
☐ 271	Co-GM1 Antibody Test	S	2 mL	R
Peripheral Neuropathy: Hereditary				
☐ **4010**	**CMT Advanced Evaluation – Initial Genetic Assessment** (PMP22 Dup./Del., GJB1 (Cx32), MPZ, MFN2 Seq.)	B	8 mL	L
☐ **4011**	**CMT Advanced Evaluation – Nonprevalent Axonal** (GJB1 (Cx32) Del., NFL, GDAP1, GARS, RAB7, HSPB1, DNM2, YARS, LMNA, TRPV4, HSPB8 Seq.)	B	8 mL	L
☐ **4012**	**CMT Advanced Evaluation – Nonprevalent Demyelinating** (GJB1 (Cx32) Del., EGR2, LITAF, PMP22, PRX, GDAP1, DNM2, YARS SH3TC2, MTMR2, NDRG1, FGD4, FIG4, SBF2 Seq.)	B	8 mL	L
☐ **4013**	**CMT Advanced Evaluation – Nonprevalent** (GJB1 (Cx32) Del., PMP22, EGR2, LITAF, PRX, GDAP1, RAB7, GARS NFL, HSPB1, LMNA, FIG4, SH3TC2, DNM2, YARS, FGD4, NDRG1, TRPV4, HSPB8, MTMR2, SBF2 Seq.)	B	8 mL	L
☐ **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, GDAP1, RAB7, GARS, NFL, HSPB1, LMNA, FIG4, SH3TC2, DNM2, YARS, FGD4, NDRG1, TRPV4, HSPB8, MTMR2, SBF2 DNA Seq.	B	8 mL	L
☐ **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
☐ **4003**	**CMT Advanced Evaluation – Dominant, Axonal*** (MFN2, MPZ, RAB7, GARS, NFL, HSPB1, LMNA, DNM2, YARS, TRPV4, HSPB8)	B	8 mL	L
☐ **4004**	**CMT Advanced Evaluation – Recessive, Demyelinating*** (PRX, GDAP1, SBF2, SH3TC2, MTMR2, NDRG1, FGD4, FIG4)	B	8 mL	L
☐ **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
☐ **4006**	**CMT Advanced Evaluation – Recessive*** (PRX, GDAP1, SBF2, LMNA, FIG4, SH3TC2, MTMR2, NDRG1, FGD4)	B	8 mL	L
☐ **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, GDAP1, DNM2, YARS, SH3TC2, MTMR2, NDRG1, FGD4, FIG4, SBF2 DNA Seq.	B	8 mL	L
☐ **4008**	**CMT Advanced Evaluation – Axonal*** (MFN2, Cx32, MPZ, RAB7, GARS, NFL, HSPB1, GDAP1, DNM2, YARS, LMNA, TRPV4, HSPB8)	B	8 mL	L
Individual CMT Tests:		B	8 mL	L
☐ 144	TRPV4*	☐ 463	HSPB8*	
☐ 354	MTMR2*	☐ 164	SBF2*	
☐ 394	NDRG1*	☐ 208	FGD4*	
☐ 253	DNM2*	☐ 468	YARS*	
☐ 221	GDAP1 (CMT2K, 4A)*	☐ 222	LITAF/SIMPLE (CMT1C)*	
☐ 223	MFN2 (CMT2A2)*	☐ 239	PRX (CMT4F)*	
☐ 247	PMP22 Seq.*	☐ 248	EGR2 (CMT1D)*	
☐ 249	NFL (CMT2E, 1F)*	☐ 131	PMP22 Dup./Del. (CMT1A)*	
☐ 134	MPZ (CMT1B, 2I, 2J)*	☐ 226	LMNA (CMT2B1, 4C1)*	
☐ 224	SH3TC2 (CMT4C)*	☐ 227	RAB7 (CMT2B)*	
☐ 225	FIG4 (CMT4J)*	☐ 228	GARS (CMT2D)*	
☐ 143	Cx32 Seq./Del. (CMTX)*	☐ 229	HSPB1 (CMT2F)*	
☐ **243**	**Complete HNPP Evaluation*** (PMP22 Sequencing, PMP22 Dup./Del.)	B	8 mL	L
☐ **245**	**Congenital Hypomyelination Evaluation*** (MPZ, EGR2)	B	8 mL	L
☐ **296**	**Entrapment Neuropathy Evaluation*** (PMP22 Seq., PMP22 Dup./Del., TTR)	B	8 mL	L
☐ 235	TTR DNA Sequencing Test*	B	8 mL	L
Peripheral Neuropathy: Hereditary Sensory Autonomic Neuropathy				
☐ 691	**Early-Onset HSAN Evaluation*** (NTRK1 and WNK1)	B	8 mL	L
☐ 698	**Late-Onset HSAN Evaluation*** (SPTLC1 and SPTLC2)	B	8 mL	L
☐ 551	SPTLC1 (HSAN I) DNA Sequencing Test*	B	8 mL	L
☐ 552	SPTLC2 (HSAN I) DNA Sequencing Test*	B	8 mL	L
☐ 553	WNK1 (HSAN II) DNA Sequencing Test*	B	8 mL	L
☐ 659	NTRK1 (HSAN IV) DNA Sequencing Test*	B	8 mL	L
☐ 660	ATL1 (HSAN I) DNA Sequencing Test*	B	8 mL	L
☐ 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

C - CSF
B - Blood
S - Serum
M - Muscle Tissue

Tube Type

P - Polypropylene CSF Transfer Tube
R - Red
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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Important: Please be sure to write in test code and test name in the Tests Ordered section on front.