SaintFrancis Hospital Center for Genetics

Shipping Address: 6161 South Yale Avenue • Tulsa, OK 74136
(918) 502-1720 Phone • (918) 502-1723 Fax • (866) 846-0315 Toll Free
www.saintfrancis.com/genetics or www.saintfrancis.com/physicians/laboratory-testing/

Kavita S. Reddy, PhD, ABMGG
(Molecular and Cytogenetics)
Director of Center for Genetics
Federal Tax # 14-1841340
Medicare # 370091 CLIA #
37D0474681 CAP # 2050201
NPI# 1740265347

MOLECULAR GENETICS LABORATORY TEST REQUISITION 411-001R front / 02-20

PATIENT / SPECIMEN INFORMATION

PATIENT NAME - *LAST, FIRST, MI*	☐ M ☐ F	SSN OR MRN	DATE OF BIRTH

RACE	DIAGNOSIS - *INDICATIONS FOR TESTING*

ICD10	SPECIMEN TYPE	COLLECTION DATE	TIME	CONSENT OBTAINED
				☐ Yes ☐ No

REFERRAL SOURCE

REQUESTING / CONTACT PHYSICIAN	**REQUESTING PHYSICIAN / PRACTITIONER SIGNATURE - (REQUIRED BY MEDICARE)**

PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE	PHONE NUMBER	FAX RESULTS **FAX** NUMBER
		☐ No ☐ Yes

REFERRING FACILITY

FACILITY ADDRESS, CITY, STATE, ZIP - *IF DIFFERENT FROM ABOVE*	PHONE NUMBER	FAX RESULTS **FAX** NUMBER
		☐ No ☐ Yes

ADDITIONAL REPORTS TO

MOLECULAR GENETICS TESTS

☐	Achondroplasia (targeted FGFR3 - G380R)	☐	Hereditary Comprehensive Cancer Profile by NGS	☐	Other:
☐	Albright Hereditary Osteodystrophy (Complete GNAS1 gene)	☐	Huntington Disease (HD)[1]	☐	
☐	ALS (Complete SOD1 gene)	☐	Hypochondroplasia (targeted FGFR3, N540K)	☐	
☐	Androgen Insensitivity Syndrome (Complete AR gene)	☐	Hypotonia Profile (DM, PWS, SMA)	☐	
☐	Angelman Syndrome (Methylation)	☐	Li-Fraumeni Syndrome (Complete TP53 gene)	☐	
☐	Apert's Syndrome (FGFR2 - exon 8)	☐	Marfan Syndrome (complete FBN1 gene)	☐	
☐	BRAF (codon 600)	☐	Marfan Syndrome - known mutation (FBN1)	☐	
☐	Beare - Stevenson Syndrome (targeted FGFR2 - exons 8,10,11)	☐	Marfan Syndrome, Type 2 - (TGFBR1) gene		**MOLECULAR ONCOLOGY**
☐	Blau Syndrome (NOD2/CARD15 Complete gene)	☐	Marfan Syndrome, Type 2 - (TGFBR2) gene	☐	BRAF (codon 600)
☐	BRCA1 / BRCA2 genes (Sequence/Deletions/Duplications)	☐	Marfan Syndrome, Type 2 Profile (TGFBR1 and TGFBR2)	☐	Colon / Lung Mutation NGS profile (22 genes)
☐	Connexin 26 gene (GJB2 Locus - Hearing Loss)	☐	Maternal Cell Contamination[3]	☐	JAK2 (V617F)
☐	Connexin 30 gene (GJB6 Locus - Hearing Loss)	☐	McCune - Albright Syndrome[2] (GNAS1 - **R201 only**)	☐	
☐	Craniodysmorphology Screen (targeted FGFR 1, 2, & 3)	☐	Mitochondrial Hearing Loss - mt A1555G mutation	☐	
☐	Craniodysmorphology Profile (targeted FGFR & TWIST)	☐	Mitochondrial Hearing Loss - MTTS1	☐	
☐	Crohn's Disease (NOD2 susceptibility markers)	☐	MTHFR		**MOLECULAR MICROBIOLOGY**
☐	Crouzon Syndrome with Acanthosis Nigricans (FGFR3 - A391E)	☐	Muenke Syndrome (only FGFR3 - P250R)	☐	BK Virus by PCR - Quantitative
☐	Cystic Fibrosis (Diagnostic and Carrier)	☐	Myotonic Dystrophy	☐	CMV DNA, Quantitative by PCR
☐	DRPLA	☐	Neurological Profile (HD, SCA, FRDA, DRPLA)	☐	Cytomegalovirus by PCR, Qualitative
☐	Dwarfism Profile (Achondroplasia & Hypochondroplasia)	☐	NOD2/CARD15 gene (Crohn's Disease) (4 Susceptibility Markers)	☐	Hepatitis B (HBV) by PCR - Quantitative
☐	Factor V Leiden	☐	NOD2/CARD15 Complete Gene Analysis	☐	Hepatitis C (HCV) by PCR - Quantitative
☐	FGFR Profile (targeted FGFR1, 2, & 3)	☐	Nonsyndromic Craniodysmorphoiogy (Muenke Syndrome)	☐	Hepatitis C (HCV) by PCR - Genotyping
☐	FGFR2 Complete Gene	☐	P53 (Li Fraumeni Syndrome)	☐	Herpes Simplex Virus (HSV Type 1 and 2) by PCR - Qualitative
☐	Fragile X Syndrome	☐	Pendred Syndrome (Complete SLC264A4 gene)	☐	Human Immunodeficiency Virus (HIV) by PCR – Quantitative
☐	Friedreich's Ataxia (FRDA)	☐	Pick Disease (FTDP) - exon 10 only		**OTHER SERVICES**
☐	FTDP (MAPT Complete gene)	☐	Pick Disease (MAPT Complete gene)	☐	Nucleic Acid Extraction
☐	GNAS1 complete gene (AHO, PHP1a)**(not McCune Albright Syn)**	☐	Prader-Willi Syndrome (Methylation)	☐	Sequencing - known mutation of any gene listed (include report)
☐	GRN Complete gene (PGRN, Granulin)	☐	Prothrombin	☐	Tier Testing
☐	Hearing Loss (Connexin26)	☐	Pseudohypoparathyroidism (GNAS1)	☐	
☐	Hearing Loss (Connexin30)	☐	Saethre-Chotzen Syndrome (TWIST)	☐	
☐	Hearing Loss - CX Profile (CX26 & CX30)	☐	SOD1 (ALS, Lou Gehrig's Disease)	☐	
☐	Hearing Loss - Full Profile (Cx26&30, mt1555)	☐	Spinal Muscular Atrophy, (SMA) (Diagnostic and Carrier)	☐	
☐	Hearing Loss - Mitochondrial Mutation A1555G	☐	Spinocerebellar Ataxia, Type 1 (SCA1)	☐	
☐	Hearing Loss - Mitochondrial Profile (mtA1555G & MTTS-1)	☐	Spinocerebellar Ataxia, Type 2 (SCA2)	☐	
☐	Hearing Loss - MTTS1	☐	Spinocerebellar Ataxia, Type 3 (SCA3; MJD)		
☐	Hearing Loss - Pendred Syndrome (SLC26A4)	☐	Spinocerebellar Ataxia, Type 6 (SCA6)		
☐	Hearing Loss - Waardenberg, type 1 & 3 (PAX3)	☐	Spinocerebellar Ataxia, Type 7 (SCA7)		
☐	Hearing Loss - Waardenberg, type 2 (MITF)	☐	Spinocerebellar Ataxia Profile (SCA1, 2, 3, 6, & 7)		
☐	Hemochromatosis Mutations by PCR/SEQ (HFE)	☐	Waardenberg Syndrome Profile (PAX3 & MITF)		
☐	Hereditary Breast and Gynecological Cancer Profile by NGS	☐	Waardenberg Syndrome, type 1 & 3 (Complete PAX3 gene)		
☐	Hereditary Colon Cancer Profile by NGS	☐	Waardenberg Syndrome, type 2 (Complete MITF gene)		

1 Consent form MUST accompany specimen (Pre-Symptomatic Patient)
2 Special Instructions : Please Call Laboratory
3 REQUIRED for all prenatal testing
4 NGS method includes SNV, Deletion and Duplication analysis

CENTER FOR GENETICS AT SAINT FRANCIS USE ONLY

DATE RECEIVED	TIME	TYPE / AMOUNT RECEIVED	ACCESSION NUMBER

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BILLING INFORMATION 411-001Q back 02-20

PAYMENT INFORMATION - *INDICATE ONE*

SELF PAY (Payment in Full from Patient or Guarantor)

Check or Money Order Payable to Saint Francis Hospital

Credit Card VISA MC	CARDHOLDER NAME - *PRINT*	ZIP CODE

ACCOUNT NUMBER	EXPIRATION DATE	SECURITY NO.	CARDHOLDER - *SIGNATURE*

Payment for Medical Care: It is understood and agreed that the undersigned or a designated agent will be responsible and assume an obligation to pay the Center for Genetics at Saint Francis all costs for genetic evaluation and testing rendered to the person whose name appears within thirty (30) days after having been notified of the amount due and owing or will work out a satisfactory payment plan with the Center for Genetics at Saint Francis. It is further understood and agreed that the undersigned or designated agent will, at all times, remain responsible for the costs of said genetic evaluation and testing.

PATIENT SIGNATURE - *MUST BE 18 YEARS OR OLDER TO SIGN* DATE

PARENT / LEGAL GUARDIAN - *REQUIRED IF PATIENT IS LESS THAT 18 YEARS OF AGE OR IS NOT LEGALLY COMPETENT*

ADDRESS, CITY, STATE, ZIP	HOME PHONE NUMBER ( )
EMPLOYER	WORK PHONE NUMBER ( )

WITNESS - *SIGNATURE* DATE

INSURANCE (Filed as Courtesy - Patient Ultimately Responsible for Balance of Account)

SUBMIT ALL OF THE INFORMATION BELOW WITH FRONT AND BACK COPY OF CARD AND REQUIRED AUTHORIZATION. INCOMPLETE SUBMISSIONS COULD DELAY TESTING. FOR OUT OF STATE PATIENTS, THE ONLY BILLABLE PLANS ARE AETNA, BLUE CROSS BLUE SHIELD, UNITED HEALTHCARE, AND CIGNA.

POLICY HOLDER NAME	POLICY HOLDER SOCIAL SECURITY NUMBER	POLICY HOLDER DATE OF BIRTH
ADDRESS, CITY, STATE, ZIP		HOME PHONE NUMBER ( )
EMPLOYER		WORK PHONE NUMBER ( )
PRIMARY CARE PHYSICIAN	PHYSICIAN NPI NUMBER	

INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE	POLICY NUMBER	GROUP NUMBER

INSURANCE COMPANY ADDRESS, CITY, STATE, ZIP CODE

REFERRAL NUMBER	REFERRAL DATE	EFFECTIVE DATE	AUTHORIZATION NUMBER

MEDICARE NUMBER	MEDICAID NUMBER (OKLAHOMA ONLY)

Authorization to Release Protected Health Information, Assign Benefits, and Accept Responsibility for My Account: I authorize any physician or laboratory who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Center for Genetics at Saint Francis. I understand that I am responsible for any co-pay or deductible amounts if the Center for Genetics at Saint Francis is a participant in my health plan. I understand I am fully responsible for payment of my account if the Center for Genetics at Saint Francis is not a participant with my health plan, and my health plan does not reimburse (or only partially reimburses) my medical services due to lack of authorization or medical necessity. **The information permitted for release may include records which indicate the presence of a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS), and/or mental health information.**

PATIENT / GUARANTOR - ***SIGNATURE*** DATE

REFERRING FACILITY

FACILITY NAME	PHONE NUMBER	FAX NUMBER
BILLING ADDRESS		