Icahn School of Medicine at Mount Sinai
One Gustave L. Levy Place, Box 1497
New York, NY 10029-6574
Phone: 212-241-7518 / Fax: 212-241-0139
Tax ID# 13-6171197
CLIA# 33D0653419

GENERAL TEST REQUISITION

Mount Sinai Genetic Testing Laboratory
Mount Sinai Medical Center

ACCESSION NO.

DATE / /

PATIENT INFORMATION

LAST NAME | FIRST NAME

DATE OF BIRTH / / | SEX ☐ M ☐ F

PARTNER / SPOUSE LAST NAME | PARTNER / SPOUSE FIRST NAME

TELEPHONE (HOME) | TELEPHONE (CELL) | TELEPHONE (WORK)

ADDRESS

CITY / STATE / ZIP

REFERRING PHYSICIAN INFORMATION

NAME | GENETIC COUNSELOR

CLINIC / INSTITUTION

ADDRESS

TELEPHONE | FAX

PHYSICIAN SIGNATURE OF CONSENT REQUIRED BELOW: I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing.

SIGNATURE | DATE (MM/DD/YY) / /

BILLING INFORMATION

POLICYHOLDER LAST NAME | POLICYHOLDER FIRST NAME | POLICYHOLDER DOB / /

INSURANCE CARRIER | INSURANCE ID | GROUP NO.

BILLING ADDRESS

OTHER HEALTH COVERAGE (IDENTIFY)

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the provider and I understand that I am financially responsible for uncovered services. I also authorize the release of any information required to process the claim. Billing inquiries, please call 212-241-8717.

SIGNATURE | DATE / /

CLINICAL INDICATIONS

SPECIMEN TYPE
☐ AMNIOTIC FLUID ☐ BLOOD ☐ CVS
☐ DBS ☐ PLASMA ☐ URINE
☐ OTHER _____
☐ CULTURED CELLS TYPE _____

DATE / TIME SPECIMEN DRAWN AM PM / /

DATE SPECIMEN SENT / /

☐ LMP / / | GESTATIONAL AGE ON SONO

INDICATIONS FOR TEST _____

Is the patient pregnant? ☐ Yes ☐ No Currently using birth control medication? ☐ Yes ☐ No

ICD9 Dx CODE(S)

LABORATORY TEST(S) ORDERED

Cytogenetics

- ☐ Amniotic Fluid - AFP and Chromosome Analysis
- ☐ CVS Chromosome Analysis
- ☐ Additional Cell Culture: ☐ Hold ☐ Grow _____ (Please indicate test required)
- ☐ Peripheral Blood
- ☐ Peripheral Blood STAT (newborn blood, includes Aneuploidy FISH)
- ☐ Fetal Blood
- ☐ High Resolution Blood
- ☐ Tissue Chromosomes
- ☐ Skin Biopsy
- ☐ Products of Conception
  (In case of growth failure, reflex to P.O.C. Fish Panel is included)
- ☐ Mosaicism Study

Molecular Cytogenetics

- ☐ Aneuploidy FISH (prenatal specimens)
- ☐ Single Microdeletion FISH
  Please specify disease: _____
- ☐ Microdeletion FISH Panel
- ☐ FISH STAT - Please specify disease: _____
- ☐ Subtelomere FISH - single probe only
- ☐ 180K Array CGH (pre-/postnatal)
- ☐ 180K Array CGH + SNPs (pre-/postnatal)
- ☐ Other: _____

☐ MaterniT21™ PLUS * **Specimen Required:** Two 10 ML Streck Tubes (Brown/Tan Top)

***Please Call 212-241-7518 for Supplies and Specimen Pickup**

SCMM ID #: _____ Fax #: _____

Ordering Physician: _____

Gestational Age: _____

Method For Determining Gestational Age: ☐ LMP ☐ Ultrasound

Patient Height: _____ **Weight:** _____

Increased Risk due to (please check one)
- ☐ Advanced Maternal Age
- ☐ Serum Biochemical Screening
- ☐ Ultrasound Finding
- ☐ Personal or Family History

If Multifetal Gestation (please check one)
- ☐ Twins
- ☐ Triplets

ICD9 Dx CODES(S) (Required)

☐ 659.63 ☐ 796.5 ☐ 655.13 ☐ 659.53 ☐ Other: _____

Molecular

For Carrier Screening, please use GENETIC SCREENING REQUISITION

- ☐ Autism Next Gen Sequencing Panel (30 genes)
- ☐ Chitotriosidase Genotype
- ☐ Chronic Kidney Disease APOL 1 Genotyping (African American)
- ☐ Fabry disease (*GLA* sequencing)
- ☐ Lysosomal Acid Lipase (*LIPA* sequencing) (Wolman Disease/Cholesteryl Ester Storage Disease)
- ☐ Maternal Contamination Studies
- ☐ Niemann-Pick A&B (*SMPD1* sequencing)
- ☐ Noonan Syndrome Next Gen Sequencing Panel (12 genes)
- ☐ Porphyria DNA Testing
  - ☐ Gene Sequencing
  - ☐ Known Mutation Analysis
    Please specify disease:
    - ☐ Acute Porphyria Panel (AIP, HCP & VP)
    - ☐ Acute Intermittent Porphyria (AIP)
    - ☐ Hereditary Coproporphyria (HCP)
    - ☐ Variegate Porphyria (VP)
    - ☐ Congenital Erythropoietic Porphyria (CEP)
    - ☐ Familial Porphyria Cutanea Tarda (fPCT)
    - ☐ Erythropoietic Protoporphyria (EPP)
- ☐ Roberts Syndrome (*ESCO2* sequencing)
- ☐ Tay-Sachs Disease (*HEXA* sequencing)
- ☐ Y Microdeletion
- ☐ Other: _____

Lab Use Only

DATE SPECIMEN RECEIVED / /

SPECIMEN RECEIVED BY

TEMP R C F	SPECIMEN	# OF TUBES
TEMP R C F	SPECIMEN	# OF TUBES

Craniosynostosis and Skeletal Dysplasia

- ☐ Achondroplasia
- ☐ Antley-Bixler syndrome
- ☐ Apert syndrome
- ☐ Beare-Stevenson Syndrome
- ☐ Carpenter Syndrome
- ☐ Craniofrontonasal Syndrome (CFNS)
- ☐ Craniosynostosis, Boston Type (CRS2)
- ☐ Craniosynostosis with Radial Defects
- ☐ Crouzon Syndrome
- ☐ Crouzon and Acanthosis Syndrome (Crouzoodermoskeletal Syndrome)
- ☐ Jackson-Weiss Syndrome
- ☐ Non-Syndromic Coronal Syndrome
- ☐ Muenke Syndrome
- ☐ Pfeiffer Syndrome
- ☐ POR Deficiency
- ☐ Saethre-Chotzen Syndrome (SC2)

Biochemical - Analyte Tests

- ☐ Amino Acids Full Panel, Plasma/Urine/CSF
- ☐ Phenylalanine/Tyrosine, DBS
- ☐ Amino Acids Selective Panel (PKU/ MSUD), Plasma
- ☐ Acylcarnitine Profile, Plasma/DBS
- ☐ Carnitine, Plasma/Urine
- ☐ Organic Acids Profile, Urine
- ☐ Orotic Acid, Urine
- ☐ Methylmalonic Acid, Plasma/Urine
- ☐ Succinylacetone, Urine
- ☐ Aminolevulinic Acid and Porphobilinogen, Urine/Plasma
- ☐ Tamoxifen Metabolites, Plasma

Biochemical - Enzyme Tests

- ☐ Hexosaminidase A (Tay-Sachs Disease), WBC/Serum
- ☐ Hexosaminidase B (Sandhoff Disease), WBC/Serum
- ☐ Acid-β-Glucosidase (Gaucher Disease), WBC
- ☐ Chitotriosidase (Gaucher Biomarker), Plasma
- ☐ α-Galactosidase A (Fabry Disease), WBC/Plasma
- ☐ Lysosomal Acid Lipase, WBC (Wolman Disease/Cholesteryl Ester Storage Disease)

MaterniT21 PLUS is a trademark of Sequenom

Limitations of the MaterniT21 PLUS Test:

DNA test results do not provide a definitive genetic risk in all individuals. Cell-free fetal DNA does not replace the accuracy and precision of prenatal diagnosis with CVS or amniocentesis. A patient with a positive test result should be referred for genetic counseling and offered invasive prenatal diagnosis for confirmation of test results. A negative test result does not ensure an unaffected pregnancy. While results of this testing are highly accurate, not all chromosomal abnormalities may be detected due to placental, maternal or fetal mosaicism, or other causes. Sex chromosomal aneuploidies will not be reported for multiple gestations.

Informed Consent for Genetic Testing

I, _____, hereby request genetic testing for me/or my child (name of child if applicable) _____, which may include molecular, cytogenetic and/or biochemical analyses. I have received verbal and/or written information from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I/or my child am about to undergo.

I understand that a specimen(s), such as peripheral blood, dried blood spot, skin biopsy, amniotic fluid, chorionic villi and/or urine sample will be taken from me/or my child. I understand that the samples will be used for determining if I/or my child have a genetic disease, are carriers of a genetic disease or are more susceptible to develop a genetic disease.

The nature of the genetic testing for (disease name) _____ _____ _____ has been explained to me and the accuracy of the test and its limitations have been detailed. I understand that although the likelihood of an incorrect diagnosis or a misinterpretation of the result is extremely small infrequent errors may occur. The likelihood of this occurring has been estimated to be less than 1%.

No test will be performed on my sample other than the one(s) authorized by my doctor.

I give consent to have my specimen be used anonymously by the laboratory for the purposes of quality control or for research related to genetic disease. Please check the box below to consent. If you do not consent your sample will be discarded within 60 days of completion of the testing.

☐ I agree to have my sample used anonymously for research by the laboratory. (initial) _____

I understand that this testing may yield results that are of unknown clinical significance and that parental or other relative's specimens may also be tested to determine whether a specific finding was inherited. An error in the diagnosis may occur if the true biological relationships of the family members involved in this study are not as I have stated and this test may detect non-paternity.

The results of my/or my child's test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a clinical geneticist.

I have had the opportunity to have all of my questions answered. If I am signing this form on behalf of a minor for whom I am the legal guardian, I am satisfied that I have received enough information to sign on his or her behalf. I understand that this consent is being obtained in order to protect my right to have all of my questions answered before testing. I also understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.

_____ _____

Signature of Person Being Tested (or guardian) Date

_____ _____

Witness Date