Biochemical Genetics Testing Requisition

Department of Pathology, Molecular and Cell-Based Medicine
Mount Sinai Health System

SPECIMENS: 1425 MADISON AVENUE ROOM 8-72 NEW YORK, NY 10029
MAIL: ONE GUSTAVE L. LEVY PLACE BOX 1612, NEW YORK, NY 10029

CLIA# 33D0653419
TAX ID# 131624096
TEL: 212-241-5227
FAX: 212-348-7556

Patient Information

LAST NAME	FIRST NAME	GENDER AT BIRTH ☐Male ☐Female
DATE OF BIRTH / /	TELEPHONE	MEDICAL RECORD NUMBER / EMAIL
STREET ADDRESS	CITY / STATE / ZIP	
INSURANCE CARRIER	INSURANCE ID / INSURANCE GROUP	
BILLING ADDRESS ☐Bill Institutional		

Referring Physician

REFERRING PHYSICIAN	FACILITY NAME
TELEPHONE / EMAIL	
STREET ADDRESS	CITY / STATE / ZIP
FAX NUMBER	EMERGENCY CONTACT NUMBER

Test(s) Ordered

DATE OF COLLECTION: DD / MM / YYYY **TIME OF COLLECTION:** HH:MM ☐AM ☐PM

CLINICAL INDICATION (Please Specify)	ICD-10 DIAGNOSIS CODE(S)	SPECIMEN(S) SUBMITTED:
		_____ # of Blood Tubes _____ Urine _____ Plasma _____ Dried Blood Spot (DBS) _____ Cerebrospinal Fluid (CSF)

Analyte Testing

- ☐ AACSF Amino Acids Full Panel, CSF
- ☐ AAP Amino Acids Full Panel, Plasma
- ☐ AASP Amnio Acids Selective Panel (PKU/MSUD), Plasma
- ☐ AAU Amino Acids Full Panel, Urine
- ☐ ACDB Acylcarnitine Profile, DBS
- ☐ ACPP Acylcarnitine Profile, Plasma
- ☐ CARNP Carnitine, Plasma Or Serum
- ☐ CARUR Carnitine, Urine
- ☐ MMAPL Methylmalonic Acid, Plasma
- ☐ MMAUR Methylmalonic Acid, Urine
- ☐ ORO Orotic Acid, Urine
- ☐ PKUD Phenylalanine/Tyrosine, DBS
- ☐ SUCC Succinylacetone, Urine
- ☐ UOA Organic Acids, Urine

Porphyria Analytes (Protect From Light)

- ☐ UPP Aminolevulinic Acid/Porphobilinogen, Urine
- ☐ PPP Aminolevulinic Acid/Porphobilinogen, Plasma

Laboratory Use Only:

Please Affix Mount Sinai SCC or Facility Label

Please Affix Mount Sinai SCC or Facility Label

Please Affix Mount Sinai SCC or Facility Label

Informed Consent for Biochemical Genetic Testing

Mount Sinai Health System
Department of Pathology,
Molecular and Cell-Based Medicine

Mount Sinai

1. I hereby authorize Mount Sinai Laboratory to perform biochemical genetic testing for: _____
(Name of "the Patient")

   Name of biochemical genetic test(s) to be performed: _____

2. I have received verbal and/or written information from my physician or from a genetic counselor or from another qualified health professional who described, in words that I understood, the nature and purpose of the biochemical genetic testing.

3. I understand that a specimen(s), such as peripheral blood, dried blood spot, urine, etc., will be taken for the testing. I understand that the specimen(s) will be used for determining whether the patient may have a genetic disease or medical condition.

4. I understand that biochemical genetic testing looks for abnormalities in the protein products that are encoded by the genes. It may or may not diagnose whether the patient has a specific disease or condition. It may or may not predict whether the patient is a carrier for the condition. Although the likelihood of an incorrect diagnosis is small, infrequent errors may occur. Optimal result interpretation often requires review of the patient's clinical status.

5. A positive result indicates that a patient may be predisposed to or have a specific disease or condition. Further testing may be needed to confirm the diagnosis. A negative result reduces, but does not eliminate the possibility that a patient has the genetic condition being tested.

6. I understand that no test will be performed and reported on the sample(s) other than the one(s) authorized by my doctor.

7. I understand that Mount Sinai Laboratory may use the patient's specimen for test validation or educational purposes after personal identifiers are removed, and the patient will receive no compensation in connection with such use. Refusal to permit the use of the patient's sample will not affect the patient's test result or result interpretation. I understand that I may withdraw my consent to the above at any time by contacting the laboratory at **212-241-5227.**
   - ☐ I decline the use of the patient's sample(s) for test validation purposes _____(Initial)
   - ☐ I decline the use of the patient's sample(s) for educational purposes _____ (Initial)

8. I understand the risks and benefits of the biochemical genetic test(s) to be performed and I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction.

9. The results of testing will be explained to me by a genetic counselor or by my physician or from another qualified health professional, who will discuss my results with a geneticist.

10. I 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, including individuals who I designate to receive this information.

	Print Name	Signature	Date and Time
Patient or Legally Authorized Representative			
Signature Witness			
Preferred Language Interpreter (if applicable)	Print Name and/or number	Signature (if present)	

Provider/Genetic Counselor's Attestation of Consent: I have explained biochemical genetic testing including the benefits, risks and limitations to the patient and have answered all questions to the best of my ability.

	Print Name	Signature	Date and Time
Provider/ Genetic Counselor			

Mount Sinai Laboratory, Biochemical Genetics Lab
One Gustave L. Levy Place, Box 1612, New York, NY 10029
T: 212-241-5227 | F: 212-348-7556