Molecular Diagnostic Request Form

Greenwood Diagnostic Labs
106 Gregor Mendel Circle • Greenwood, SC 29646
Toll Free: (800) 473-9411 • Fax: (864) 941-8141
Website: www.GGC.org Highlighted boxes are required

LAB USE ONLY

Patient Information (Please Print):

Last Name First MI		Address	
Race/Ethnicity	Sex ☐ M ☐ F	DOB MM/DD/YYYY	City, State, Zip
Specimen Collection Date MM/DD/YYYY	Type of specimen*	Numeric Identifier (Medical record # or SSN)	Home telephone

*DNA samples only: Please identify where DNA extraction was performed.
☐ **CAP/CLIA Accredited Lab:** _____ ☐ **Research Lab:** _____ ☐ **Unknown**

Referring Physician:

Name		Address	
Institution		City, State, Zip	
NPI#		Telephone	Fax
Email Address:		Preferred Method to Receive Results: ☐ Secure Email ☐ Fax ☐ Regular Mail	

Additional report to: ☐ **Genetic Counselor** ☐ **Institution** ☐ **Care Coordinator** ☐ **Other:**

Name			Address
Telephone	Fax	Email:	City, State, Zip

Additional report to: ☐ **Genetic Counselor** ☐ **Institution** ☐ **Care Coordinator** ☐ **Other:**

Name			Address
Telephone	Fax	Email:	City, State, Zip

Billing: Select how the test(s) will be billed & complete the billing information on the next page. The BILLING FORM on page 2 is required.

☐ **Institutional Billing: Complete section 1 on the separate BILLING FORM (page 2)**
☐ **Insurance: Complete section 2 on the BILLING FORM (page 2). Insurance or Medicaid for out-of-state (non-SC) patients is not accepted.**
☐ **Self-pay: Complete section 3 on the separate BILLING FORM (page 2).**

Indication for Study & Clinical Information:

☐ ICD10 Code(s): _____
☐ Symptomatic, specific findings: _____
☐ Family History _____
☐ Targeted mutation analysis for known mutation(s)- specify gene and alteration _____
☐ Proband name (if tested at GGC): _____ Proband DOB: _____ Study # _____
☐ Relationship to proband: _____ Symptomatic: ☐Yes ☐No

Is the patient currently pregnant? ☐ No ☐ Yes If so, provide LMP: _____ or EDC: _____ Gestational Age: _____

Ultrasound findings_____

Full sequencing of select genes may be requested for prenatal samples based on ultrasound findings, and targeted mutation analysis may be available for familial pathogenic variants. Please contact the laboratory prior to sending prenatal samples.

***Maternal cell contamination studies are required for all prenatal testing and recommended for analysis on cord blood specimens**
Please send 3-5 ml of maternal blood in EDTA tube or a saliva sample.

☐ Maternal Cell Contamination

Comments: _____

_____

If multiple tests are requested, please indicate the order in which testing should be completed or if all tests should be performed simultaneously.

Purple top (EDTA) tube is the preferred sample and accepted for all tests listed.
In addition, extracted DNA, saliva, and dried blood spots are accepted for most tests (DBS is not accepted for triplet repeat analysis or MLPA).
*** Requires Qiagen PAXGENE tube (available upon request) and purple top (EDTA) tube**
♦ Single gene del/dup analysis via CytoScan Xon array – cannot be performed from a dried blood spot

LAB USE ONLY Accessioned By: Event Codes: FedEx Eagle UPS DHL WC USPS Other:

EDTA	Na Hep	Plasma / Serum	Urine	Flasks / Tissue	DBS / DNA	Saliva / Swab Buccal	PAX	ACD
RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F

Diagnostic Laboratory Billing Form

This page is required to process any test requests.

LAB USE ONLY

- **Out of State (non-SC) commercial insurance can only be filed for NGS Panels.**
- **No out of state Medicaid will be accepted for any tests.**
- **The following items are needed in order to bill the patient's insurance directly. We will not be able to file the claim if we are missing information.**
  - ☐ **This form must be completed with ALL requested information.**
  - ☐ **A legible copy of both sides of the insurance card**
  - ☐ **Authorization number, authorization letter, or letter of agreement from insurance company**

Patient Information:

Last Name First MI		Address	
Numeric Identifier (Medical record # or SSN)	DOB MM/DD/YYYY	City, State, Zip	Telephone
ICD10 Code(s)			

Section 1: Institutional Billing

Complete section below with institution information. *New clients must complete an INSTITUTIONAL ACCOUNT REQUEST FORM when submitting the order.* Please contact the GGC Billing Office at 864-941-8117 or billing@ggc.org with any questions about your account.

Institution/Organization	Contact Name:	Email:
Billing Address	City, State, Zip	
Account Number:	Telephone	Fax

Section 2: Insurance Information INSURANCE OR MEDICAID FOR OUT-OF-STATE (NON-SC) PATIENTS IS NOT ACCEPTED

MUST INCLUDE LEGIBLE COPY OF INSURANCE CARD (FRONT & BACK)
All information required to file insurance claims.

Primary

Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender ☐ Male ☐ Female
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone

Secondary

Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender ☐ Male ☐ Female
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone

I authorize Greenwood Genetic Center (GGC) Diagnostic Laboratories to furnish any medical information requested of me, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to GGC Diagnostic Laboratories. I understand I am responsible for any co-pay, deductibles, non-authorized, or non-covered services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if the GGC Diagnostic Laboratories is not a participant with my health plan, or my health plan does not fully reimburse my medical services due to lack of authorization for medical necessity.

Printed Name:_____ Signature:_____ Date (MM/DD/YY):_____

Section 3: Self-pay

We accept check/Visa/MasterCard/American Express/Discover. All information required to process credit card payments.
Payments will be processed prior to initiation of testing.

Payment Method: ☐ Check ☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover	Credit Card Number:	
Amount: (with discount applied if applicable)	Exp. Date	CVV
Cardholder Name (print as it appears on the card):	Cardholder Signature:	Date
Billing address	City, State, Zip	Telephone

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- ☐ 3-Methylcrotonylglycinuria *(MCCC1 and MCCC2)* Sequencing
- ☐ 3-Methylcrotonylglycinuria *(MCCC1 and MCCC2)* Del/Dup ♦
- ☐ Aarskog syndrome *(FGD1)* Sequencing
- ☐ Aarskog syndrome *(FGD1)* Del/Dup ♦
- ☐ Acid Sphingomyelinase Deficiency (*SMPD1*) Sequencing
- ☐ Acid Sphingomyelinase Deficiency (*SMPD1*) Del/Dup ♦
- ☐ Adrenoleukodystrophy, X-linked (*ABCD1*) Sequencing
- ☐ Adrenoleukodystrophy, X-linked (*ABCD1*) Del/Dup ♦
- ☐ Alpha-Mannosidosis *(MAN2B1)* Sequencing
- ☐ Alpha-Mannosidosis *(MAN2B1)* Del/Dup ♦
- ☐ Aminoglycoside-induced hearing loss *(MTRNR1)* A1555G
- ☐ Angelman syndrome Methylation-Specific MLPA
- ☐ Angelman syndrome (*UBE3A)* Sequencing
- ☐ Angelman syndrome (*UBE3A)* Del/Dup ♦
- ☐ *ARX*-related X-linked intellectual disability *(ARX)* Sequencing
- ☐ *ARX*-related X-linked intellectual disability *(ARX)* Del/Dup ♦
- ☐ Aspartylglycosaminuria (*AGA*) Sequencing
- ☐ Aspartylglycosaminuria (*AGA*) Del/Dup ♦
- ☐ Beckwith-Wiedemann syndrome *(CDKN1C)* Sequencing
- ☐ Beckwith-Wiedemann syndrome Methylation-Specific MLPA
- ☐ Beta-mannosidosis (*MANBA*) Sequencing
- ☐ Beta-mannosidosis (*MANBA*) Del/Dup ♦
- ☐ Biotinidase deficiency (*BTD*) Sequencing
- ☐ Biotinidase deficiency (*BTD*) Del/Dup ♦

- ☐ Carnitine palmitoyltransferase deficiency IA (*CPT1A*) Sequencing
- ☐ Carnitine palmitoyltransferase deficiency IA (*CPT1A*) Del/Dup ♦
- ☐ Carnitine palmitoyltransferase II deficiency (*CPT2*) Sequencing
- ☐ Carnitine palmitoyltransferase II deficiency (*CPT2*) Del/Dup ♦
- ☐ Central Hypoventilation Syndrome (*PHOX2B*) Polyalanine Repeat
- ☐ Central Hypoventilation Syndrome (*PHOX2B*) Sequencing
- ☐ Central Hypoventilation Syndrome (*PHOX2B*) Del/Dup ♦
- ☐ Charcot-Marie-Tooth Disease, Type IA (*PMP22*) Del/Dup (MLPA)
  CMT NGS Multigene Panel also available – use NGS Requisition form
- ☐ *CHD7*-related disorders Sequencing
- ☐ *CHD7*-related disorders Del/Dup ♦
- ☐ Citrullinemia, Type 1 (*ASS1*) Sequencing
- ☐ Citrullinemia, Type 1 (*ASS1*) Del/Dup ♦
- ☐ Coffin-Lowry syndrome *(RPS6KA3)* Sequencing
- ☐ Coffin-Lowry syndrome *(RPS6KA3)* Del/Dup ♦
- ☐ Connexin 26 *(GJB2)* Sequencing
- ☐ Connexin 26 *(GJB2)* Del/Dup ♦
- ☐ Copper Transport disorders (*ATP7A*) Sequencing
- ☐ Copper Transport disorders (*ATP7A*) Del/Dup ♦
- ☐ Creatine transporter deficiency syndrome *(SLC6A8)* Seq *PAX
- ☐ Creatine transporter deficiency syndrome *(SLC6A8)* Del/Dup ♦
- ☐ Cystic Fibrosis *(CFTR)* Sequencing
- ☐ Cystic Fibrosis *(CFTR)* Del/Dup ♦
- ☐ Duchenne/Becker Muscular Dystrophy *(DMD)* Del/Dup (MLPA)
- ☐ Fabry disease (*GLA*) Sequencing
- ☐ Fabry disease (*GLA*) Del/Dup ♦
- ☐ Familial Hypercholesterolemia (*LDLR*) Del/Dup (MLPA)
  Familial Hypercholesterolemia NGS Multigene Panel also available – use NGS Requisition form
- ☐ *FGFR2*-related disorders (*FGFR2*) Sequencing
- ☐ *FGFR2*-related disorders Targeted (check all that apply)
  - ☐ Apert syndrome
  - ☐ Crouzon syndrome
  - ☐ Jackson-Weiss syndrome
  - ☐ Pfeiffer syndrome with *FGFR1* reflex
- ☐ *FGFR2* – related Beare-Stevenson with cutis gyrata
- ☐ *FGFR2*-related disorders Del/Dup ♦
- ☐ *FGFR3*-related disorders (must select the phenotype(s) below)
  - ☐ Achondroplasia
  - ☐ Crouzon with acanthosis nigricans
  - ☐ Hypochondroplasia
  - ☐ Non-syndromic craniosynostosis
  - ☐ Thanatophoric dysplasia type I
  - ☐ Thanatophoric dysplasia type II
  - ☐ Other _____
- ☐ *FGFR3*-related disorders ♦
- ☐ Fragile X syndrome (FMR1) triplet repeat analysis + methylation
- ☐ Fragile X syndrome *(FMR1)* methylation analysis only
- ☐ Fucosidosis (*FUCA1)* Sequencing
- ☐ Fucosidosis (*FUCA1)* Del/Dup ♦
- ☐ Galactosemia, Classic *(GALT)* Sequencing
- ☐ Galactosemia, Classic *(GALT)* Del/Dup ♦
- ☐ Galactosialidosis (*CTSA*) Sequencing
- ☐ Galactosialidosis (*CTSA*) Del/Dup ♦
- ☐ Gaucher disease (*GBA*) Sequencing
- ☐ Gaucher disease (*GBA*) Del/Dup ♦
- ☐ Glutaric acidemia, type 1 *(GCDH)* Sequencing
- ☐ Glutaric acidemia, type 1 *(GCDH)* Del/Dup ♦
- ☐ GM1-gangliosidosis (*GLB1*) Sequencing
- ☐ GM1-gangliosidosis (*GLB1*) Del/Dup ♦
- ☐ *GNAS*-related disorders (*GNAS*) Methylation-Specific MLPA
  (Only blood and DNA drawn from blood accepted for *GNAS* MS-MLPA)
- ☐ Hunter syndrome *(IDS)* Sequencing (with reflex to MLPA)
- ☐ Hunter syndrome *(IDS)* Del/Dup (MLPA only)
- ☐ Hurler syndrome (*IDUA*) Sequencing
- ☐ Hurler syndrome (*IDUA*) Del/Dup ♦
- ☐ Kabuki syndrome (*KMT2D*) Sequencing
- ☐ Kabuki syndrome (*KMT2D*) Del/Dup ♦
- ☐ Kabuki syndrome 2 *(KDM6A)* Sequencing
- ☐ Kabuki syndrome 2 *(KDM6A)* Del/Dup ♦
- ☐ Krabbe disease (*GALC*) Sequencing
- ☐ Krabbe disease (*GALC*) Del/Dup ♦
- ☐ Marfan syndrome (*FBN1*) Sequencing
- ☐ Marfan syndrome (*FBN1*) Del/Dup ♦
- ☐ Maroteaux-Lamy syndrome (*ARSB*) Sequencing
- ☐ Maroteaux-Lamy syndrome (*ARSB*) Del/Dup ♦
- ☐ Maternal Cell Contamination
- ☐ MCAD deficiency (*ACADM*) Sequencing
- ☐ MCAD deficiency (*ACADM*) Del/Dup ♦
- ☐ Metachromatic Leukodystrophy *(ARSA)* Sequencing
- ☐ Metachromatic Leukodystrophy *(ARSA)* Del/Dup ♦
- ☐ Morquio syndrome A, MPS IVA (*GALNS*) Sequencing
- ☐ Morquio syndrome A, MPS IVA (*GALNS*) Del/Dup ♦
- ☐ Morquio syndrome B, MPS IVB (*GLB1*) Sequencing
- ☐ Morquio syndrome B, MPS IVB (*GLB1*) Del/Dup ♦
- ☐ Mucolipidosis II & III Alpha/Beta *(GNPTAB)* Sequencing
- ☐ Mucolipidosis II & III Alpha/Beta *(GNPTAB)* Del/Dup ♦
- ☐ Mucolipidosis III Gamma (*GNPTG*) Sequencing
- ☐ Mucolipidosis III Gamma (*GNPTG*) Del/Dup ♦
- ☐ Myotonic dystrophy *(DMPK)* Triplet repeat analysis (No saliva or DBS)
- ☐ Myotubular myopathy, X-linked (*MTM1*) Sequencing
- ☐ Myotubular myopathy, X-linked (*MTM1*) Del/Dup ♦
- ☐ Neuronal ceroid lipofuscinosis Type 1 (*PPT1*) Sequencing
- ☐ Neuronal ceroid lipofuscinosis Type 1 (*PPT1*) Del/Dup ♦
- ☐ Neuronal ceroid lipofuscinosis Type 2 (*TPP1*) Sequencing
- ☐ Neuronal ceroid lipofuscinosis Type 2 (*TPP1*) Del/Dup ♦
- ☐ Ornithine transcarbamylase deficiency (*OTC*) Sequencing
- ☐ Ornithine transcarbamylase deficiency (*OTC*) Del/Dup ♦
- ☐ Pelizaeus-Merzbacher disease (*PLP1*) Sequencing
- ☐ Pelizaeus-Merzbacher disease (*PLP1*) Del/Dup (MLPA)

Purple top (EDTA) tube is the preferred sample and accepted for all tests listed.
In addition, extracted DNA, saliva, and dried blood spots are accepted for most tests (DBS is not accepted for triplet repeat analysis or MLPA).
*** Requires Qiagen PAXGENE tube (available upon request) and purple top (EDTA) tube**
♦ Single gene del/dup analysis via CytoScan Xon array – cannot be performed from a dried blood spot

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- ☐ **Phenylketonuria *(PAH)* Sequencing**
- ☐ **Phenylketonuria *(PAH)* Del/Dup ♦**
- ☐ **Pompe disease,** glycogen storage disease type II **(*GAA*) Sequencing**
- ☐ **Pompe disease,** glycogen storage disease type II **(*GAA*) Del/Dup (MLPA)**
- ☐ **Prader-Willi syndrome Methylation-Specific MLPA**
- ☐ **Primary carnitine deficiency, systemic (*SLC22A5*) Sequencing**
- ☐ **Primary carnitine deficiency, systemic (*SLC22A5*) Del/Dup ♦**
- ☐ ***PTEN*-related disorders Sequencing**
  Specific phenotype _____
- ☐ ***PTEN* Del/Dup (MLPA)**
- ☐ ***PTPN11*-related disorders Sequencing**
- ☐ ***PTPN11*-related disorders Del/Dup ♦**
- ☐ **Rett syndrome (*MECP2*) Sequencing**
- ☐ **Rett syndrome *(MECP2)* Del/Dup (MLPA)**
- ☐ **Russell-Silver syndrome (11p15.5-related) Methylation-Specific MLPA**
- ☐ **Saethre-Chotzen syndrome *(TWIST1)* Sequencing**
- ☐ **Saethre-Chotzen syndrome *(TWIST1)* Del/Dup (MLPA)**
- ☐ **Sandhoff disease *(HEXB)* Sequencing**
- ☐ **Sandhoff disease *(HEXB)* Del/Dup ♦**
- ☐ **Sanfilippo A *(SGSH)* syndrome Sequencing**
- ☐ **Sanfilippo A *(SGSH)* syndrome Del/Dup ♦**
- ☐ **Sanfilippo B *(NAGLU)* syndrome Sequencing**
- ☐ **Sanfilippo B *(NAGLU)* syndrome Del/Dup ♦**
- ☐ **Sanfilippo C (*HGSNAT*) syndrome Sequencing**
- ☐ **Sanfilippo C (*HGSNAT*) syndrome Del/Dup ♦**
- ☐ **Sanfilippo D (*GNS*) syndrome Sequencing**
- ☐ **Sanfilippo D (*GNS*) syndrome Del/Dup ♦**
- ☐ **SCAD deficiency (*ACADS*) Sequencing**
- ☐ **SCAD deficiency (*ACADS*) Del/Dup ♦**
- ☐ **Sialidosis (*NEU1*) Sequencing**
- ☐ **Sialidosis (*NEU1*) Del/Dup ♦**
- ☐ **Sly syndrome, MPS VII (*GUSB*) Sequencing**
- ☐ **Sly syndrome, MPS VII (*GUSB*) Del/Dup ♦**
- ☐ **Sotos syndrome (*NSD1*) Sequencing**
- ☐ **Sotos syndrome (*NSD1*) Del/Dup (MLPA)**
- ☐ **Spinal muscular atrophy (*SMN1*) Sequencing**
- ☐ **Spinal muscular atrophy (*SMN1/SMN2*) Del/Dup (MLPA)**
- ☐ **Spinocerebellar Ataxia (5 genes) Expansion Analysis Panel**
- ☐ **Spinocerebellar Ataxia 1 (*ATXN1*) Expansion Analysis**
- ☐ **Spinocerebellar Ataxia 2 (*ATXN2*) Expansion Analysis**
- ☐ **Spinocerebellar Ataxia 3 (*ATXN3*) Expansion Analysis**
- ☐ **Spinocerebellar Ataxia 6 (*CACNA1A*) Expansion Analysis**
- ☐ **Spinocerebellar Ataxia 7 (*ATXN7*) Expansion Analysis**
- ☐ **STRC-Related Disorders (*STRC*) Sequencing**
- ☐ **STRC-Related Disorders (STRC) Del/Dup (MLPA)**
- ☐ **Tay-Sachs disease (*HEXA*) Sequencing**
- ☐ **Tay-Sachs disease (*HEXA*) Del/Dup ♦**
- ☐ **Thrombosis Panel**
  - ☐ **Factor V Leiden**
  - ☐ **Prothrombin c.G20210A**
- ☐ ***TP63*-related disorders Sequencing**
  Specific phenotype _____
- ☐ ***TP63*-related disorders Del/Dup ♦**
- **Uniparental Disomy–**Parental samples w/ TRFs required**
  Contact lab prior to ordering for cases of segmental UPD.
- ☐ **Chromosome 7 UPD** (Russell-Silver syndrome)**
- ☐ **Chromosome 14 UPD****
- ☐ **Chromosome 15 UPD** (Angelman/Prader-Willi syndrome)**
- ☐ **VLCAD deficiency *(ACADVL)* Sequencing**
- ☐ **VLCAD deficiency *(ACADVL)* Del/Dup ♦**
- ☐ **X-inactivation analysis**
- ☐ **X-linked Hydrocephalus *(L1CAM)* Sequencing**
- ☐ **X-linked Hydrocephalus *(L1CAM)* Del/Dup ♦**

- ☐ **DNA Banking**

Please complete the clinical findings form for the below tests.

☐ **Focused Del/Dup ♦ Custom Requests** Specify the gene(s) if not listed above: _____

Available via CytoScan Xon Microarray for most single genes and custom panel requests.
Please contact the laboratory prior to submission to confirm coverage of the requested gene(s).

☐ **EpiSign Complete (Blood or DNA from blood only)** ☐ **Include Fetal Valproate syndrome**

☐ **EpiSign Variant (Blood or DNA from blood only)** Specify condition: _____

Please specify any variants identified with previous molecular testing below, or attach a copy of the report.

Gene/Variant: _____

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