



Molecular Diagnostic Request Form
 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 <input type="checkbox"/> M <input type="checkbox"/> 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. <input type="checkbox"/> CAP/CLIA Accredited Lab: _____ <input type="checkbox"/> Research Lab: _____ <input type="checkbox"/> Unknown					

Referring Physician:

Name		Address			
Institution		City, State, Zip			
NPI#		Telephone		Fax	
Email Address:		Preferred Method to Receive Results: <input type="checkbox"/> Secure Email <input type="checkbox"/> Fax <input type="checkbox"/> 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	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	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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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: <input type="checkbox"/> Check <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AmEx <input type="checkbox"/> 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

Last Name	First	MI	DOB	Numeric Identifier (Medical record # or SSN)
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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 ♣
- 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 gyratea
- 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 Del/Dup ♣
- 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
- 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 ♣
- Mucopolipidosis II & III Alpha/Beta (*GNPTAB*) Sequencing
- Mucopolipidosis II & III Alpha/Beta (*GNPTAB*) Del/Dup ♣
- Mucopolipidosis III Gamma (*GNPTG*) Sequencing
- Mucopolipidosis 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 ♣
- Niemann-Pick A/B disease (*SMPD1*) Sequencing
- Niemann-Pick A/B disease (*SMPD1*) 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

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

<input type="checkbox"/> DNA Banking |
|--|--|

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)

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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 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