Molecular Request Form

Greenwood Genetic Center
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/YYY	Type of specimen*	Numeric Identifier (Medical record # or SSN)	Home telephone

*DNA samples only: Please identify where DNA extraction was performed and source of DNA (blood, fibroblasts, etc.).
☐ **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). WE DO NOT ACCEPT INSURANCE OR MEDICAID FOR NON-SC PATIENTS.**
☐ **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 variant 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 or panels 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:
_____
_____
_____

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

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Diagnostic Laboratory Billing Form

This page is required to process any test requests.

LAB USE ONLY

- **No out of state (non-SC) insurance 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 WE DO NOT ACCEPT INSURANCE OR MEDICAID FOR NON-SC PATIENTS.

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**
- ☐ **Acid Sphingomyelinase Deficiency (*SMPD1*) Sequencing**
- ☐ **Adrenoleukodystrophy, X-linked (*ABCD1*) Sequencing**
- ☐ **Alpha-Mannosidosis *(MAN2B1)* Sequencing**
- ☐ **Angelman syndrome Methylation-Specific MLPA**
- ☐ **Aspartylglycosaminuria (*AGA*) Sequencing**
- ☐ **Beckwith-Wiedemann syndrome *(CDKN1C)* Sequencing**
- ☐ **Beckwith-Wiedemann syndrome Methylation-Specific MLPA**
- ☐ **Biotinidase deficiency (*BTD*) Sequencing**
- ☐ **Carnitine palmitoyltransferase deficiency IA (*CPT1A*) Sequencing**
- ☐ **Central Hypoventilation Syndrome (*PHOX2B*) Polyalanine Repeat**
- ☐ **Central Hypoventilation Syndrome (*PHOX2B*) Sequencing**
- ☐ **Charcot-Marie-Tooth Disease, Type IA (*PMP22*) Del/Dup (MLPA)**
- ☐ **Connexin 26 *(GJB2)* Sequencing**
- ☐ **Cystic Fibrosis *(CFTR)* Sequencing**
- ☐ **Duchenne/Becker Muscular Dystrophy *(DMD)* Del/Dup (MLPA)**
- ☐ **Fabry disease (*GLA*) Sequencing**
- ☐ **Familial Hypercholesterolemia (*LDLR*) Del/Dup (MLPA)**
- ☐ **Fragile X syndrome (*FMR1*) triplet repeat analysis + methylation**
- ☐ **Fragile X syndrome *(FMR1)* methylation analysis only**
- ☐ **Galactosemia, Classic *(GALT)* Sequencing**
- ☐ **Gaucher disease (*GBA*) Sequencing**
- ☐ **Glutaric acidemia, type 1 *(GCDH)* Sequencing**
- ☐ **GM1-gangliosidosis (*GLB1*) Sequencing**
- ☐ ***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**
- ☐ **Krabbe disease (*GALC*) Sequencing**
- ☐ **Maroteaux-Lamy syndrome (*ARSB*) Sequencing**
- ☐ **Maternal Cell Contamination**
- ☐ **MCAD deficiency (*ACADM*) Sequencing**
- ☐ **Metachromatic Leukodystrophy *(ARSA)* Sequencing**
- ☐ **Morquio syndrome A, MPS IVA (*GALNS*) Sequencing**
- ☐ **Morquio syndrome B, MPS IVB (*GLB1*) Sequencing**
- ☐ **Myotonic dystrophy *(DMPK)* Triplet repeat analysis**
- ☐ **Pelizaeus-Merzbacher disease (*PLP1*) Del/Dup (MLPA)**
- ☐ **Phenylketonuria *(PAH)* Sequencing**
- ☐ **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**
- ☐ ***PTEN*-related disorders Sequencing**
  Specific phenotype: _____
- ☐ ***PTEN* Del/Dup (MLPA)**
- ☐ **Rett syndrome (*MECP2*) Sequencing**
- ☐ **Rett syndrome (*MECP2*) Del/Dup (MLPA)**
- ☐ **Russell-Silver syndrome** (11p15.5-related) Methylation-Specific **MLPA**
- ☐ **Saethre-Chotzen syndrome *(TWIST1)* Del/Dup (MLPA)**
- ☐ **Sanfilippo A *(SGSH)* syndrome Sequencing**
- ☐ **Sanfilippo B *(NAGLU)* syndrome Sequencing**
- ☐ **Sanfilippo C (*HGSNAT*) syndrome Sequencing**
- ☐ **Sanfilippo D (*GNS*) syndrome Sequencing**
- ☐ **Sialidosis (*NEU1*) Sequencing**
- ☐ **Sly syndrome, MPS VII (*GUSB*) 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**
- ☐ **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**
- ☐ **X-inactivation analysis**

☐ **DNA Banking**

☐ **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: _____

Specimen Requirements:
Peripheral blood collected in an EDTA (lavender top) tube is the preferred sample type and accepted for all tests listed. Extracted DNA, saliva, and dried blood spots are accepted for most tests (DBS is not accepted for triplet repeat analysis, MLPA, or X-inactivation). The specimen should be kept at room temperature and delivered via overnight shipping.

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NGS Panels

- ☐ **Aortic Dysfunction/Dilation & Related Disorders Panel**
- ☐ **Cholestasis Panel**
- ☐ **Comprehensive Cardiac Panel**
- ☐ **Comprehensive Pulmonary Panel**
- ☐ **Connective Tissue Disorders Panel**
- ☐ **Craniosynostosis Panel**
- ☐ **Dilated Cardiomyopathy (DCM)/Arrhythmogenic Cardiomyopathy Panel**
- ☐ **Epilepsy/Seizure Panel**
- ☐ **Facioscapulohumeral Muscular Dystrophy Type 2 (FSHD2) Panel**
- ☐ **Familial Hypercholesterolemia Panel**
- ☐ **Hearing Loss Panel**
- ☐ **Hermansky-Pudlak Syndrome and Pulmonary Fibrosis Panel**
- ☐ **Maturity-Onset Diabetes of the Young Panel**
- ☐ **Non-Immune Hydrops Panel – Solid tissue also accepted**
- ☐ **Ocular Albinism and Hermansky-Pudlak Syndrome Panel**
- ☐ **Overgrowth/Macrocephaly Panel**
- ☐ **RASopathy Panel**
- ☐ **Rhabdomyolysis and Metabolic Myopathies Panel**
- ☐ **Skeletal Dysplasia Panel**
- ☐ **Vascular Disorders Panel**

☐ **Reflex to QUICK Analysis if sequencing panel above is not informative** (no charge for this reflex)

☐ **Focused NGS Custom Requests** Specify the gene(s): _____

_____

Available for most single genes and custom panel requests up to 60 genes. Please contact the laboratory prior to submission to confirm coverage of the requested genes.

☐ **Follow-up studies for Known Familial Variant** Specify gene & mutation: _____ Symptomatic: ☐Yes ☐No

Proband Name: _____ DOB: _____ Relationship to proband: _____

Mitochondrial (mtDNA) Analysis

☐ **Mitochondrial DNA Variant Panel**

☐ **Targeted Sanger Analysis: Known Familial Mutation** ☐ **Targeted NGS Analysis with Heteroplasmy: Known Familial Mutation**

Specify variant: _____ Symptomatic: ☐Yes ☐No

If proband tested at GGC: Name _____ DOB: _____ Relationship: _____

Note:
Peripheral blood collected in an EDTA (lavender top) tube is the preferred sample type and accepted for all tests listed. Extracted DNA, saliva, and dried blood spots are accepted for most tests (DBS is not accepted for triplet repeat analysis, MLPA, or X-inactivation). The specimen should be kept at room temperature and delivered via overnight shipping.

All NGS panels have transitioned to the genome backbone, which allows for the detection of SNVs and CNVs. **If saliva is submitted, and the extracted DNA is below quality control, then you will be contacted to submit a blood sample or the panel can be completed on the exome backbone.**

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