NGS Panel 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 ☐ 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 BCBS 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: _____

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

Ultrasound findings_____

Please attach pedigree

Select panels may be requested for prenatal samples, and targeted mutation analysis may be available for familial pathogenic variants previously identified on one of these panels. Please contact the laboratory prior to sending prenatal samples.

Maternal cell contamination studies are required for prenatal testing. Please send 3-5 ml of maternal blood in EDTA tube or a saliva sample.

☐ Maternal Cell Contamination

Comments:

_____

_____

Specimen Requirements: 3-5 ml of peripheral blood collected in an EDTA (lavender top) Vacutainer tube. The specimen should be kept at room temperature and delivered via overnight shipping. Extracted DNA and saliva are also accepted unless otherwise indicated.

Please complete the Clinical Information on page 4.

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

Greenwood Diagnostic Labs

Diagnostic Laboratory Billing Form

This page is required to process any test requests.

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- **Out of State (non-SC) commercial insurance can only be filed for NGS Panels.**
- **No out of state (non-SC) 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 WE DO NOT ACCEPT BCBS 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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Last Name	First	MI	DOB	Numeric Identifier

- ☐ **Aortic Dysfunction/Dilation & Related Disorders Panel**
- ☐ **Bardet-Biedl Syndrome Panel**
- ☐ **Brugada Syndrome Panel**
- ☐ **Central Hypoventilation Syndrome Panel**
- ☐ **Charcot-Marie-Tooth Hereditary Neuropathy Panel**
- ☐ **Charcot-Marie-Tooth Tiered Testing includes**
  Tier 1: Charcot-Marie-Tooth, Type IA (*PMP22*) MLPA with automatic reflex if normal to Tier 2
  Tier 2: Charcot-Marie-Tooth Hereditary Neuropathy Panel
- ☐ **Cholestasis Panel**
- ☐ **Coffin-Siris Syndrome Panel**
- ☐ **Comprehensive Cardiac Panel**
- ☐ **Comprehensive Pulmonary Panel**
- ☐ **Cone-Rod Dystrophy Panel**
- ☐ **Congenital Contractures Panel**
- ☐ **Congenital Stationary Night Blindness Panel**
- ☐ **Connective Tissue Disorders Panel**
- ☐ **Cornelia de Lange Panel**
- ☐ **Craniosynostosis Panel**
- ☐ **Dilated Cardiomyopathy (DCM)/Arrhythmogenic Cardiomyopathy Panel**
- ☐ **Dyskeratosis Congenita Panel**
- ☐ **Early Infantile Epileptic Encephalopathy Panel**
- ☐ **Epilepsy/Seizure Panel**
- ☐ **Familial Hypercholesterolemia Panel**
- ☐ **Familial Hypercholesterolemia Tiered Testing includes**
  Tier 1: Familial Hypercholesterolemia Panel with automatic reflex if normal to Tier 2
  Tier 2: Familial Hypercholesterolemia (*LDLR*) MLPA
- ☐ **Hearing Loss Panel**
- ☐ **Hereditary Spastic Paraplegia Panel**
- ☐ **Hermansky-Pudlak Syndrome and Pulmonary Fibrosis Panel**
- ☐ **Hypertrophic Cardiomyopathy Panel**
- ☐ **Kallmann Syndrome and Hypogonadotropic Hypogonadism Panel**
- ☐ **Leber Congenital Amaurosis Panel**
- ☐ **Long QT Syndrome Panel**
- ☐ **Lysosomal Storage Disorders Panel**
- ☐ **Macular Degeneration Panel**
- ☐ **Maturity-Onset Diabetes of the Young Panel**
- ☐ **Mitochondrial Depletion Panel**
- ☐ **Neuromuscular Disorders Panel**
- ☐ **Neuronal Ceroid Lipofuscinoses Panel**
- ☐ **Non-Immune Hydrops Panel (87 genes) – Solid tissue also accepted**
- ☐ **Ocular Albinism and Hermansky-Pudlak Syndrome Panel**
- ☐ **Optic Atrophy and Early Glaucoma Panel**
- ☐ **Overgrowth/Macrocephaly Panel**
- ☐ **Periodic Fever Panel**
- ☐ **Peroxisomal Biogenesis Disorders Panel**
- ☐ **Primary Ciliary Dyskinesia and Cystic Fibrosis Panel**
- ☐ **Pulmonary Arterial Hypertension Panel**
- ☐ **RASopathy Panel**
- ☐ **Retinitis Pigmentosa Panel**
- ☐ **Rett/Angelman Syndrome Panel**
- ☐ **Rhabdomyolysis and Metabolic Myopathies Panel**
- ☐ **Skeletal Dysplasia Panel**
- ☐ **Surfactant Dysfunction and Respiratory Distress in Premature Infants Panel**
- ☐ **Syndromic Autism Panel**
- ☐ **Tuberous Sclerosis Complex Panel**
- ☐ **Vascular Disorders Panel**
- ☐ **X-Linked Intellectual Disability (XLID) Panel**

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

☐ **Deletion/Duplication Analysis for Selected Panel (Separate charges will apply)**
Do you want the deletion/duplication analysis run ☐ **Simultaneously** ***OR*** ☐**Sequentially** with the sequencing panel?

☐ **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: _____

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Please provide clinical information regarding the proband being tested. Check all that apply. If a feature is selected, please provide an additional description of the finding. Use blank space on right to provide other relevant details.

Growth

- ☐ Failure to thrive_____
- ☐ Microcephaly (OFC <3rd centile) _____
- ☐ Macrocephaly (OFC >97th centile) _____
- ☐ Short stature (Ht <3rd centile) _____
- ☐ Tall stature (Ht >97th centile) _____
- ☐ Obesity/Overgrowth _____

Neurological/Muscular

- ☐ Spasticity/Hyperreflexia _____
- ☐ Ataxia _____
- ☐ Tremors _____
- ☐ Hypotonia _____
- ☐ Seizures _____
- ☐ Abnormal movements _____

Development, Physical & Cognitive

- ☐ Delayed motor milestones _____
- ☐ Intellectual disability _____
- ☐ Speech/Language delay _____
- ☐ Developmental regression _____

Craniofacial, Ophthalmologic, Auditory

- ☐ Vision Loss _____
- ☐ Hearing loss/Deafness _____
- ☐ Dysmorphic facies _____
- ☐ Eye anomalies _____
- ☐ Ear anomalies _____

Skeletal & Limb Anomalies

- ☐ Limb malformation _____
- ☐ Joint contractures _____
- ☐ Craniosynostosis _____
- ☐ Hyperextensibility _____

Congenital Anomalies

- ☐ Heart malformations _____
- ☐ Kidney abnormalities _____
- ☐ Genital abnormality _____
- ☐ Brain malformations _____
- ☐ Gastrointestinal anomalies _____
- ☐ Other _____

Other Features

- ☐ Prematurity _____
- ☐ Intrauterine growth restriction _____
- ☐ Autism/Autism Spectrum Disorders _____
- ☐ Metabolic abnormalities _____
- ☐ Mitochondrial abnormalities _____
- ☐ Pigmentary abnormalities _____
- ☐ Other skin findings _____
- ☐ Organomegaly _____
- ☐ Cancer/tumor formation_____

You may also attach a pedigree and/or clinic note as additional supporting information.

Additional Information