HRG HIBM Research Group
Nonprofit Molecular Laboratory

http://www.hibm.org/hrg
Tel & Fax: (818) 789-1033

# TEST REQUISITION FORM (DNA & GENETIC TESTS)

INCLUDE THE FIRST 3 PAGES OF THIS FORM WITH SPECIMEN. Before sending specimens, please contact us for pre-authorization procedures. Samples received without billing pre-authorization cannot be processed.

| REPORTING INFORMATION | ADDITIONAL REPORTS |
|---|---|
| *Ordering Physician or Genetic Counselor* | *Copy of report should be sent to* |
| Name: | Name: |
| Email: | Email: |
| Institution: | Fax: ( ) |
| Address: | |
| City, State, Zip: | Name: |
| Phone: ( ) | Email: |
| Fax: ( ) | Fax: ( ) |

## PATIENT INFORMATION

*Patient's Last Name, First Name, MI* | *Birthdate (mm/dd/yyyy)* | *Gender* ☐M ☐F

*Indication or reason for testing (check all that apply)*

☐Diagnosis ☐Asymptomatic family member ☐Confirm recorded mutation: _____

☐High risk population (state Ancestry or Ethnic background below) ☐Prenatal screening ☐Ongoing pregnancy

☐Other: _____

*Ancestry or Ethnic Background (check all that apply)* | *Patient's country of origin* | *Ethnic Background*

☐Hispanic ☐Jewish ☐Asian ☐European ☐Middle-Eastern
☐American ☐Muslim ☐African ☐Caucasian ☐Other (Specify)

*Hospital or Clinic Patient ID* | *Specimen ID* | *Diagnosis (ICD9 codes)*

## SPECIMEN INFORMATION (REQUIRED)

*Specimen Date/Time Collected* | *Collected by (initial)* | *Specimen Type (If other, please contact us before shipping)*

/ / _____:_____ AM/PM ☐Buccal ☐Blood ☐Other:

Specimen may be submitted as whole blood or buccal epithelial cells (2 swabs / patient). Transport at room temperature.
For other specimens and more details, see page labeled "Specimen Requirements".

## TESTS REQUESTED (Ask us to customize the requisition form for your practice)

| *Test No.* | *Test Name* | |
|---|---|---|
| 1. | Middle Eastern Carrier Panel | ☐Stat |
| 2. | | ☐Stat |
| 3. | | ☐Stat |

Test Names are found on the list at the end of this form. The tests will be performed in the order listed. Turnaround times are usually less than 5 weeks following receipt of specimen. Sequential panels of several large genes will take longer depending on which gene positive results are found. STAT is available for self-pay or institution accounts only, and reduces turnaround by >50% (less than 10 days / single gene) for an additional 25% cost.

**I am the referring/ordering clinician and I have reviewed the required patient informed consent information. I accept responsibility for pre- and post-test genetic counseling.**

Signature: _____ Date: _____

Full Name: _____



**For Lab Use Only** Received by: Date/Time received:

Specimen type received: Requisition complete? Yes / No

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## BILLING INFORMATION & PRE-AUTHORIZATION

Please complete one of the below billing sections. If the requisition or billing information section is incomplete, we are not able to process the specimen. For institution/clinic and grant awarded payers, please contact us for bulk test pricing.

**INSTITUTION ACCOUNT/BILLING** (Complete this section if institution or clinic is responsible for payment.)

| | | |
|---|---|---|
| *Institution* | | *P.O. Number (If applicable)* |
| *Contact/Responsible Person's Name* | *Email* | |
| *Phone Numbers* | | *Fax* |
| *Address to which invoice should be sent (Street, City, State Zip)* | | *Send invoice by (check all that apply)* ☐Email ☐Fax ☐Address |

**SELF PAY OR INSURANCE** (Complete this section if the patient or insurance is responsible for payment.)

| | | |
|---|---|---|
| *Responsible Person's Last Name, First Name, MI* | *Email* | |
| *Phone Numbers* | | *Fax* |
| *Address (Street, City, State, Zip)* | | *Send invoice by (check all that apply)* ☐Email ☐Fax ☐Address |

I authorize the furnishing of any medical information requested on myself, or my covered dependents. For services rendered, I transfer and assign benefits of insurance to the laboratory. I understand that I am responsible for any co-pay, co-insurance, deductible, or other non-covered service amounts even if my health plan does not cover or fully reimburse my medical services.

Patient/Guardian or responsible party's signature: _____ Date: ____/____/_____

Print Name: _____

**Please attach legible copy of <u>both sides of the Insurance Card and Drivers License, or Patient Demographics</u>. Some insurance companies require pre-authorization. Please contact us for pre-authorization procedures.** We are a Medicare provider, and we accept most PPO plans.



**For Lab Use Only** Received by: Date/Time received:

Pre-authorization: Notes:

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# INFORMED CONSENT FOR GENETIC TESTING

Patient Name: _____ Birth Date: ____/____/_____ Sex: [ ] M [ ] F

I request the following test(s) ordered: _____

The intended purpose is: ☐Diagnosis ☐Carrier screening ☐Confirm recorded mutation
☐Prenatal screening ☐Ongoing pregnancy

The Department of Health and Human Services defines genetic testing as "…an analysis performed on human DNA, RNA, genes and/or chromosomes to detect heritable or acquired genotypes, phenotypes, or karyotypes that cause or are likely to cause a specific disease or condition. A genetic test is also the analysis of human proteins and certain metabolites, which are predominantly used to detect heritable or acquired genotypes, mutations, or phenotypes."

The result of genetic testing may irreversibly affect your future. Before testing, you should be well informed about the possible test results and how it may affect your life. The implications that may arise from the test results may involve both medical and psychosocial issues. The lab reports the test results only to the ordering physician, yourself, or another person of your choosing. Although the Genetic Information Nondiscrimination Act (GINA) of 2008 was signed into law, it is still possible that the result of genetic tests may lead to undesired discriminations (insurance, work-related, other). Genetic testing performed by the laboratory is highly accurate. However, due to technological and scientific limitations, some genetic testing may not always give a definite answer as desired. Usually, genetic test results may: (a) diagnose whether or not you have, or may be at risk for, a genetically inherited condition, (b) indicate whether or not you are a carrier for a condition, (c) predict if another family member has, is at risk for developing, or is a carrier of a genetically inherited condition, (d) be indeterminate due to technical limitations or familial genetic patterns, or (e) reveal non-paternity when both father and child are tested.

This genetic test is specific only for the tests requested (named above). It may not detect all mutations possible within this gene, nor detect mutations in other genes. Your sample, or your children's or fetus' samples, may be used for validation of future tests and/or educational purposes after personal identifiers are removed (irreversibly de-identified). For such use, the sample(s) may be stored for up to 20 years. If any de-identified sample test result shows that the health of the donor (the person from whom sample was obtained) may be at significant risk by a potentially serious disease, an informative letter will be mailed to everyone whose sample may have been included in the batch of de-identified samples. Refusal to permit the use of your sample for such future test validation and/or educational purposes will not affect the results of the tests ordered above. You can withdraw your consent at any time by contacting the laboratory.

Please be sure to provide your physician with accurate reports of family medical history and biological relationships. Test interpretation may depend on accurate family history information. Also, it is the patient's responsibility alone to inform other family members of possible genetic risks they may have. In some cases, genetic testing may reveal previously unrecognized biological relationships, such as non-paternity or a genetic condition in another family member. Genetic analysis is a fee-for-service test. You will be responsible for payment after the testing has begun, even if you decide not to receive the results.

I request and authorize the use of my sample for genetic testing. My signature below constitutes my acknowledgment that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified clinician. I authorize the release of my test result to the clinician listed below.

_____ _____
Print patient's name Print Name of Legal Guardian (If patient is below 18 years of age)

_____ _____ _____
Signature Relationship to patient Date

## Clinician (Physician, Genetic Counselor, or Qualified Healthcare Professional)

I, the referring clinician, have reviewed this form with the patient and/or patient's parent or guardian. I have explained genetic testing and its limitations to the patient or legal guardian and answered all questions.

_____ _____
Print clinician's name, relevant degree Institution, City, State Zip

_____ _____ _____
Signature Date Phone / Fax / Email (preferred method of contact)

## SPECIMEN REQUIREMENTS

**This page is for information only and does not have to be returned with specimen.**

### Whole Blood

Collect in either EDTA (lavender top) or ACD (yellow top) Vacutainer tubes. Submit at least 5 ml. Do not use whole blood from patients who have been recipients of a bone marrow transplant or whole blood products in the past 6 months; use buccal epithelial cells instead. Please ship blood at room temperature. **Do not freeze**.

### Buccal Swab

Obtain by rubbing buccal collection swab inside the cheeks (buccal). Gently rub the collection tip for up to 20 seconds per swab to absorb maximum number of epithelial cells. Submit at least 2 swabs. Contact us for buccal collection kits that can be used by your office staff with minimal training. Please ship buccal/mouth swabs at room temperature. **Do not freeze**.

### Purified DNA

Send at least 15 µg purified DNA at minimum concentration of 20 ng/µL. Ship DNA in a secured/sealed tube. For sequencing of multiple large genes, please send an additional 5 µg DNA per gene.

Tube **label** should include:
- Patient name or ID linked to name
- DNA concentration
- Buffer/solute information

Please send genomic DNA for testing. Do not send of whole genome amplification products or other laboratory amplified DNA segments unless pre-arranged for specialized testing.

DNA may be shipped at room temperature if not already frozen, or if DNA is already frozen may ship with dry ice to avoid freeze/thaw cycles.

### Other

Cells, biological fluids, or other sources of genomic DNA may be used depending on case by case basis. Please contact us for information, pre-arrangement, and guidance as needed. Thank you.

## SHIPPING INSTRUCTIONS

Ship specimens to the following address on the top right corner of this form.

**HRG Laboratory**
**21053 Devonshire St., #106**
**Chatsworth, CA 91311**

Do not hesitate to contact us for additional information as needed. Thank you.

Phone: (818) 789-1033 or 1-800-338-5037
Customer Service Email: cs@hibm.org