UW MEDICINE CENTER FOR PRECISION DIAGNOSTICS
NORTHWEST CLINICAL GENOMICS LABORATORY
1959 NE PACIFIC AVE., LAB H-561, SEATTLE, WA 98195
PHONE: 206-543-0459; FAX: 206-616-1899 www.uwcpdx.org

NEUROLOGY TEST REQUISITION

PATIENT INFORMATION			ORDERING PHYSICIAN		
Name:			Name:		
Address:			Organization:		
City:	State:	ZIP:	Address:		
Phone (home):			City:	State:	ZIP:
Phone (other):			Phone:	FAX:	
Date of birth:	MRN:		Email:		
Gender: ☐ Male ☐ Female ☐ Unknown			**OTHER REPORT RECIPIENT**		
Ethnic background (select all that apply):			Name:		
☐ African American ☐ Hispanic			Address:		
☐ Caucasion (White) ☐ Asian			City:	State:	ZIP:
☐ Ashkenazi Jewish ☐ Native American			Phone:	FAX:	
☐ Other:			Email:		

SAMPLE INFORMATION

Date of collection:

Specimen type: ☐ Whole blood (lavender top - EDTA tube) ☐ Extracted DNA Other:

FAMILIAL (BIOLOGICAL) SAMPLES

Mother:		Father:	
Date of birth:	Date of collection:	Date of birth:	Date of collection:
☐ Whole blood	☐ Extracted DNA	☐ Whole blood	☐ Extracted DNA
☐ Asymptomatic	☐ Symptomatic	☐ Asymptomatic	☐ Symptomatic

TEST(S) TO BE PERFORMED

Repeat expansion testing

☐ Spinocerebellar Ataxia: 1,2,3,6,7 ☐ Fragile X associated ataxia
☐ Huntington's Disease ☐ C9orf72 hexanucleotide expansion

If a NGS panel is also requested, **repeat expansion testing** is to be performed: ☐ prior to intiating the NGS panel **OR** ☐ concurrently with the NGS panel

If reflexing to a NGS panel: ☐ Please contact provider prior to intiating NGS testing **OR** ☐ Reflex automatically to the NGS panel

Please provide 2 lavender top tubes of blood if you are ordering repeat expansion testing and NGS, or if you expect to reflex from repeat expansion testing to NGS.

Next Generation Sequencing (NGS) Panels

For the NGS panels below, select any or all the phenotypes relevant to your patient within the prescribed panel. If none of the panels fit your testing needs, select up to any six phenotypes below to create a custom panel.

Movement Disorder

☐ Ataxia ☐ Dystonia/Choreatic Movement ☐ Parkinson's Disease
☐ Hereditary Spastic Paraplegia

Neurodegenerative Disorder

☐ Dementia (Alzheimer's / FTD) ☐ Neuronal Ceroid Lipofuscinosis ☐ Amyotrophic Lateral Sclerosis
☐ Basal Ganglia Calcification ☐ Leukoencephalopathy ☐ Neurodegeneration with Brain Iron Accumulation

Neuromuscular Disorder

☐ Charcot-Marie-Tooth & Neuropathies ☐ Myesthenic Syndromes & Arthrogryposis ☐ Myopathies/Myotonia, Muscular Dystrophies, and Limb Girdle Muscular Dystrophies
☐ Spinal Muscular Atrophy ☐ Walker Warburg
☐ Metabolic Myopathies

Custom Panel

☐ Select up to **six** phenotypes from the NGS panels listed above; use web tool at https://ncgl.uwcpdx.org/panel-on-demand/ to create a custom panel.

Record 5 character Panel On Demand code here: _____

REQUISITION FORM

Patient name: _____ Date of birth: _____ (MM/DD/YYYY)

CLINICAL INFORMATION

Indication for Study and Pertinent Clinical Information (provide any suspected clinical diagnoses or state if unaffected):

_____
_____
_____
_____
_____
_____
_____

Please include clinic note if available.

Previous Genetic Testing: ☐ **No** ☐ **Yes - Provide results:** _____

Suspected Mode of Inheritance: ☐ **Dominant** ☐ **Recessive** ☐ **X-linked** ☐ **De novo** ☐ **Mitochondrial**

ICD-10 Code(s): _____

EXOME PANEL TESTING DESCRIPTION

The genes in each panel are sequenced as part of the sequence of an entire exome. For each gene in the designated panel all coding nucleotides are sequenced in at least 20 different fragments (20x coverage) or the fragment is sequenced by Sanger methodology. We have chosen this approach to sequence all known candidate genes. If no mutations are identified, then examination of the entire exome is available by re-analysis of the sequence (request Reflex to Exome Sequencing) without additional laboratory work.
During panel test analysis and interpretation, variants detected in other genes, even those in those deemed "medically actionable" by the ACMG guidelines, are not examined but can be provided when *Reflex to Exome Sequencing* is requested. The Reflex study is completed on request with appropriate consent from the patient/family. Clinicians are encouraged to translate these limitations of panel testing by exome to the patient and to contact the NCGL laboratory directors with any related questions.

RESEARCH POLICIES & OPPORTUNITIES

Blood or other samples sent to the Northwest Clinical Genomics Laboratory (NCGL) may be used by UW Medicine, by medical organizations affiliated with UW Medicine, or by educational or business organizations approved by UW Medicine, for research, education and other activities that support UW Medicine's mission, without your/your child's specific consent. Other types of research performed in association with the NCGL require that we obtain consent from the patient (below).

PATIENTS – Please check off and initial below whether we can contact you to let you know about research studies requiring consent in which you/your child may be able to participate. These research studies may include: 1) a request for additional clinical records about your condition, 2) studies to find new causes for your condition, and 3) studies to evaluate newly developed treatments for your condition.

Patient Name: _____ Date of Birth: _____ / _____ / _____ (MM/DD/YYYY)

Please check one: ☐ _____ Yes, you can contact me _____ (Patient/Guardian initials)
If yes, please provide your contact information on the first page of the requisition form.

☐ _____ No, please do not contact me _____ (Patient/Guardian initials)

BILLING INFORMATION AND AUTHORIZATION

Insurance Billing Pre-Authorization (not offered for tests <$500)

☐ **Do insurance preauthorization; PROCEED if approved (PREAUTH FORM and sample required)**
☐ **Do insurance preauthorization; CONTACT PROVIDER before proceeding (PREAUTH FORM and sample required)**
☐ **PROCEED to testing without preauthorization (add billing information below)**

1. BILL INSTITUTION			
Institution:	Tax ID #:	PO#:	
Claims Billing Address:	City:	State:	Zip:
Billing Contact Name:	Phone:	FAX:	

2. BILL INSURANCE (SEE PRE-AUTH ABOVE)			
Policyholder Name:	Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse	Other (specify):	
Policyholder DOB:	Dates of Coverage:		
Patient Policy ID#:	Group Name:	Group #:	
Insurance Company Name:			
Claims Billing Address:	City:	State:	Zip:
Phone:	FAX:		
ICD9 Diagnosis Code(s):			

3. SELF-PAY			
Payment Method: ☐ Cashier Check / Money Order (Payable to *UW Physicians*)			
☐ Visa ☐ MasterCard ☐ AmEX ☐ Discover			
Amount (USD):	(Amount authorized to be charged)		
Card #:	Expiration Date:	CVV#:	
Name of Cardholder:			
Billing Address:	City:	State:	Zip:
Electronic Funds Transfer (EFT) (See website for details)			
EFT Amount (USD):			

4. MEDICAID
For Medicaid billing, the following is <u>required</u>:
1. Medicaid claims address
2. Copy of Medicaid card (attach to requisition form)
3. Letter of medical necessity from referring physician; impact on future care (attach to requisition form)

SAMPLE & SHIPPING REQUIREMENTS

Blood samples should be collected in lavender top (potassium EDTA) tubes: 7mL (3-5mL for infants). All samples must be labeled with two unique identifiers: 1) the patient's full name and 2) date of birth. If possible please include the patient's medical record number. Please contact the laboratory for more details and test kits.

Samples must be accompanied by a requisition form and signed consent forms (when applicable).
Sample (with forms) should be shipped overnight at room temperature to:

Center for Precision Diagnostics
Northwest Clinical Genomics Laboratory
1959 NE Pacific St., HSC H-561
Seattle, WA 98195

For more detailed information about shipping requirements and procedures, please contact the lab at 206-543-0459.