

UW LABORATORY 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	OTHER REPORT RECIPIENT		
Ethnic background (select all that apply):			Name:		
African American			Hispanic		
Caucasian (White)			Asian		
Ashkenazi Jewish			Native American		
Other:			Address:		
			City:	State:	ZIP:
			Phone:		FAX:
			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 initiating the NGS panel **OR** concurrently with the NGS panel

If reflexing to a NGS panel: Please contact provider prior to initiating 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 Hereditary Spastic Paraplegia	Dystonia/Choreatic Movement	Parkinson's Disease
Neurodegenerative Disorder	Dementia (Alzheimer's / FTD) Basal Ganglia Calcification	Neuronal Ceroid Lipofuscinosis Leukoencephalopathy	Amyotrophic Lateral Sclerosis Neurodegeneration with Brain Iron Accumulation
Neuromuscular Disorder	Charcot-Marie-Tooth & Neuropathies Spinal Muscular Atrophy Metabolic Myopathies	Myesthenic Syndromes & Arthrogyposis Walker Warburg	Myopathies/Myotonia, Muscular Dystrophies, and Limb Girdle Muscular Dystrophies
Custom Panel	Select up to six phenotypes from the NGS panels listed above; use web tool at https://hagl.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

1. BILL INSTITUTION

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

2. BILL INSURANCE

Preauthorization is <u>required</u> for all insurance billing. All patients should sign insurance billing consent (below).					
Do insurance preauthorization; PROCEED if approved (PREAUTH FORM and sample required)					
Do insurance preauthorization CONTACT PROVIDER if approved (PREAUTH FORM and sample required)					
Preauthorization already obtained; PreAuth approval number:					
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:				
ICD10 Diagnosis Code(s):					
Patient Insurance Billing Consent:					
I authorize the NCGL to release to my designated insurance carrier, health plan, or third party administrator the information on this form and any other information provided by my health care provider necessary for reimbursement. I assign and authorize insurance payments to NCGL. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity, or otherwise. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State or Federal law. A duplicate or faxed copy of this authorization is considered the same as the original document.					
Patient Signature:			Date:		

3. SELF-PAY

Payment Method:	Cashier Check/Money Order (Payable to UW Physicians)
Credit Card: Please contact NCGL billing at (206) 221-1274 to provide credit card information over a secure line	
Electronic Funds Transfer (EFT) (See website for details) EFT Amount (USD):	

4. MEDICAID

For Medicaid billing, the following is required: Medicaid claims address, Copy of Medicaid card (attach to requisition form), Letter of medical necessity from referring physician; impact on future care (attach to requisition form)

5. MEDICARE

For Medicare billing, a completed Advance Beneficiary Notice (ABN) is required (see website for 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 (206-543-0459).

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:

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