UW SPS: Do not log - forward to the REFRIGERATED pass-through bin / NWH, SCCA, all other SPS: send to UW SPS

UW MEDICAL CENTER
LABORATORY MEDICINE - GENETICS LABORATORY
1959 NE PACIFIC AVE., ROOM NW220, SEATTLE, WA 98195
PHONE: 206-543-0459; FAX: 206-616-1899 www.uwcpdx.org

# EXOME PANEL TEST REQUISITION

## PATIENT INFORMATION

Name:
Address:
City: State: ZIP:
Phone (home):
Phone (other):
Date of birth: MRN:
Gender: ☐ Male ☐ Female ☐ Unknown

Ethnic background (select all that apply):

☐ African American ☐ Hispanic
☐ Caucasian (White) ☐ Asian
☐ Ashkenazi Jewish ☐ Native American
☐ Other:

## ORDERING PHYSICIAN

Name:
Organization:
Address:
City: State: ZIP:
Phone: FAX:
Email:

## OTHER REPORT RECIPIENT

Name:
Address:
City: State: ZIP:
Phone: FAX:
Email:

## SAMPLE INFORMATION

Date of collection: Collected by:
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 |
| Other: | | Other: | |
| 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 TO BE PERFORMED

☐ Cardiac Arrhythmia Panel
☐ Cardiomyopathy Panel
☐ Comprehensive Cardiac Arrhythmia/Cardiomyopathy Panel
☐ Retinal Dystrophy Panel

☐ Known Mutation Testing (Sanger Sequencing)
Gene Variant
Proband (if tested at NCGL):
Relationship to Proband:

☐ Single Gene Sequencing*
☐ Micro Exome Panel on Demand (2-10 genes*)
☐ Mega Exome Panel on Demand (11-100 genes*)
☐ Super Exome Panel on Demand (101-200 genes*)
☐ Hyper Exome Panel on Demand (201-500 genes*)

***Use web tool at https://ncgl.uwcpdx.org/panel-on-demand/ to add genes to a custom panel**

RECORD 5 CHARACTER 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 required for all insurance billing

- ☐ 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:

**UW Medical Center**
**Laboratory Medicine - Genetics Lab**
**1959 NE Pacific St., Room NW220**
**Seattle, WA 98195**