



CENTER for PRECISION DIAGNOSTICS

"Powering Precision Medicine"

Pathology and Laboratory Medicine
Clinic Building, K6, Core Lab, E-655
2799 W. Grand Blvd.
Detroit, MI 48202
855.916.4DNA (4362)

GENETIC HEREDITARY DISORDER REQUISITION

Required Patient Information

Ordering Physician Information

Name: _____ Gender: M F

Name: _____

MRN: _____ DOB: MM / DD / YYYY

Address: _____

ICD10 Code(s): _____ / _____ / _____

City: _____ State: _____ Zip: _____

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only those tests that are medically necessary for the diagnosis and treatment of the patient.

Phone: _____ Fax: _____

Billing Information

Patient Demographic/Billing/Insurance Form is required to be submitted with this form. Most genetic testing requires insurance prior authorization. Due to high insurance deductibles and member policy benefits, patients may elect to self-pay. Call for more information (855.916.4362)

Bill Client or Institution Client Name: _____ Client Code/Number: _____

Bill Insurance Prior authorization or reference number: _____

Patient Self-Pay Call for pricing and payment options Toll Free: 855.916.4362

Patient status at time of collection: Inpatient Outpatient

Providers are responsible to obtain informed consent, as required by Michigan law, for predictive or pre-symptomatic genetic tests. Informed Consent for Genetic Testing form is available on our website.

Required Information

Will the results of the ordered test(s) affect treatment? Yes No

Is this treatable, preventable or neither? Treatable Preventable Neither

Has there been any genetic counseling? Yes No

FOR CYSTIC FIBROSIS AND FAMILIAL MEDITERRANEAN FEVER TESTING:

TYPE OF TESTING: Carrier Screen Diagnostic

ETHNICITY: African American Arab American Ashkenazi Jewish Caucasian Hispanic Asian Other: _____

Specimen Submission Requirements

Peripheral blood in lavender (EDTA) top tube (minimum volume: 3 mL) | Specimen Stability: Ambient – 72 hours; Refrigerated – 1 week. **DO NOT FREEZE**

EXTRACTED DNA ONLY ACCEPTED FROM CLIA CERTIFIED LABORATORIES

Hereditary Disorders (Germline)

All tests include pathologist interpretation at a separate, additional charge

Factor V (Leiden) (81241)
-Has the patient been diagnosed with a DVT? Yes No

Cystic Fibrosis Screening Panel (81220, [reflex, if needed 81224 (Poly T)])

Prothrombin 20210 G → A (81240)

Fragile X Syndrome (81243)
-Family history of Fragile X or mental retardation? Yes No

Methylenetetrahydrofolate reductase (MTHFR) (81291)

Hereditary Hemochromatosis (HFE) (81256)

Spinal Muscular Atrophy (SMA) Carrier Screen (81401x2)

Familial Mediterranean Fever (81402)

Other Molecular DNA/RNA Tests

Send Additional Report To

Name: _____

Address: _____

Phone #: _____

Fax #: _____



INFORMED CONSENT FOR GENETIC TESTING

PATIENT LAST NAME: (Please Print)		FIRST NAME:	MI:
DATE OF BIRTH: MM/DD/YYYY		PATIENT ID/MRN NUMBER:	
ORDERING PROVIDER INFORMATION (FULL LAST, FIRST): Name: Phone:		GENETIC TESTING REQUESTED FOR: _____ (name of condition)	
<p style="text-align: center;">SAMPLE TYPE</p> <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Blood <input type="checkbox"/> Cheek swab <input type="checkbox"/> Chorionic villus sample (CVS) <input type="checkbox"/> Skin <input type="checkbox"/> Tissue block <input type="checkbox"/> Other _____		<p>The intended purpose is (check all that apply):</p> <input type="checkbox"/> Carrier status <input type="checkbox"/> Diagnostic <input type="checkbox"/> Predictive <input type="checkbox"/> Prenatal <input type="checkbox"/> Pre-symptomatic <input type="checkbox"/> Screening <input type="checkbox"/> Other _____	

- I have been informed about the nature and the purpose of this genetic test.
- I have received an explanation of the effectiveness and limitations of this genetic test.
- I have discussed the benefits and risks of this genetic test with my physician and/or other health care professional. I understand some genetic tests can involve possible medical, psychological or insurance issues for my family and me.
- I understand the meaning of possible test results and have been informed how I will receive the result.
- I have been informed that genetic testing can sometimes reveal secondary findings-results that are not related to the purpose of testing. I have discussed with my health care professional if and/or how such results will be shared with me. I understand that it is up to me to decide whether I want secondary results reported back to me and what secondary results I want reported.
- I have been informed who may have access to my biological sample, and that any leftover sample may be retained by the laboratory.
- I have been informed who may have access to my genetic test result, which is part of my confidential medical record.
- My questions have been answered to my satisfaction.
- I understand that this consent form is intended to be used together with the patient information booklet that contains important information explaining the above eight items. I have read both this consent form and the booklet. I received a copy of the form and booklet for my records.

I consent to have a sample taken for genetic testing on the above-named patient for the condition(s) listed above.

Signature of Patient or Authorized Designee Date

Circle one: **Self** **Parent(s)** **Legal Guardian** **Durable Power of Attorney for Health Care**

Print Name of Physician or Authorized Delegee explaining the above information:

Signature of Authorized Person: _____ Date: _____