

CGC Genetics CLIA#: 99D1066287

IGM-UMDNJ CLIA#: 31D1085261 - CAP#: 7215375

Pre-Payment Test Requisition – June 2011

* Indicates REQUIRED information

Patient ID

Physician ID

Patient Identification

Patient Name* First _____ Last _____

Patient ID # (if available) _____

S.S. # _____

Date of Birth* mm ____ / dd ____ / yy ____

Sex* Male Female Unknown

Ethnicity* African American Asian Caucasian Hispanic

Jewish Specify _____

Mailing Address* _____

State* _____ City* _____

Zip* _____ Country* _____

Phone #1* _____ Day Eve Cell

Phone #2 _____ Day Eve Cell

Pre-Payment

Payment Type*

Mastercard Visa American Express Discover

Card Number* _____

Exp Date* mm ____ / yy ____ Cardholder Name* _____

CVC/CVV* _____ (3-4 digit code; back of the card) Amount* \$ _____

Date* mm ____ / dd ____ / yy ____

Patient Acknowledgment

I hereby authorize the amount of the test to be paid directly to CGC Genetics, Inc and authorize them to release medical information concerning my testing to my physician. I hereby acknowledge I am financially responsible for the entire amount(s) of the test(s).

SIGNATURE* _____

Physician/Laboratory Contact Information

Contact Name First _____ Last _____

Phone _____ Fax _____

Email _____

Tests ordered*

Important: Write in the test code and the test name (see list on reverse)

Code _____ Name _____

Code _____ Name _____

ICD-9 Code* _____

For BAbs/Nabs Testing, please provide IF-B start date: mm ____ / dd ____ / yy ____

Indications for testing (Check one)*

Ama

Abnormal Fetal Ultrasound. Specify: _____

Increase Risk at Prenatal Screening. Specify: _____

Family History of:

Chromosomal Abnormality. Specify: _____

Genetic Disease. Specify: _____

Mental Retardation

Other: _____

Parent Carrier of Chromosomal Rearrangement. Specify: _____

Recurrent Miscarriage

Infertility

Parental Analysis in the Context of Current PND. Specify: _____

Development Delay

Clinical Features of Chromosome Abnormality. Specify: _____

Other: _____

Testing Authorization

I warrant that this test was ordered and is either: 1) for the purpose of diagnosing or detecting an existing disease, illness, impairment, symptom or disorder, or 2) that if is not for such purpose, I have obtained the appropriate prior written consent. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person), and includes: a) a statement of the purpose and description of the test; b) a statement that prior to signing the consent form, the consenting person discussed with the medical practitioner ordering the test the reliability of positive or negative test results and the level of certainty that a positive test result for that disease or condition serves as a predictor of such disease; c) a statement that the consenting person was informed about the availability and importance of further testing, physician consultation and genetic counseling, and provided with written information identifying a genetic counselor or medical geneticist from whom the consenting person might obtain such counseling; d) a general description of each specific disease or condition testing for; and e) the person or persons to whom the test results may be disclosed as indicated above.

MEDICAL PRACTITIONER SIGNATURE* _____

Specimen Type

Note: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, social security no., patient ID no. These same two forms of ID should also be indicated on the test requisition.

Blood (Heparin) Buccal swab Fetal blood Amniotic Fluid

CVS Tissue (specify): _____

Collection date: mm ____ / dd ____ / yy ____

GA on US: _____ weeks _____ days

LMP: _____ #Gestations: _____

PARA _____ SPAB _____ TOP _____

Required Physician Information

NPI#* _____ UPIN#* _____

Name* First _____ Last _____

Address _____

City _____ State _____ Zip _____ Country _____

Phone #* _____ Day Eve Cell Fax# _____

Email _____

Additional Authorized Report Recipient

Name First _____ Last _____

UPIN# or CLIA# _____

Address _____

City _____ State _____ Zip _____ Country _____

Phone # _____ Day Eve Cell Fax# _____

Email _____

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TEST REQUEST*

CGC Mutation Panel® • PATENT PENDING •

- 0001 Bardet-Biedl Syndrome**
130 mutations on genes: ARL6, BBS1, BBS2, BBS4, BBS5, BBS7, BBS9, BBS10, BBS12, MKKS, MKS1, TRIM32 and TTC8
- 0002 Congenital Deafness (Nonsyndromic)**
136 mutations on genes: ACTG1, CDH23, COCH, CRYM, DNFA5, DIAPH1, GJA1, GJB2, GJB3, GJB6, KCNQ4, MYH14, MYO1A, MYO7A, OTOA, OTOF, POU3F4, SLC26A4, SLC26A5,TECTA, TMC1 and WFS1
- 0003 Congenital Deafness (Syndromic)**
176 mutations on genes: CDH23, EYA1, GJB2, KCNE1, KCNQ1, MYO7A, PAX3, PCDH15, SIX1, SIX5, SLC26A4, USH1C, USH1G and WFS1
- 0004 Congenital Deafness (Syndromic and Nonsyndromic) Combined Panel**
312 mutations
- 0005 Craniosynostosis**
52 mutations on genes: FGFR1 (Pfeiffer), FGFR2 (Apert, Crouzon, Jackson-Weiss and Pfeiffer), FGFR3 (Muenke and Saethre-Chotzen) and RAB23 (Carpenter)
- 0006 Fraser Syndrome**
15 mutations on genes: FREM2 and FRAS1
- 0007 Metabolic Disorders**
93 mutations on genes: ACADM (MCAD), ARSA (Metachromatic leukodystrophy), ATP7B (Wilson disease), BTBD (Biotinidase deficiency), CLN2/TPP1 (Neuronal Ceroid Lipofuscinosis), CLN5 (Neuronal Ceroid Lipofuscinosis), CLN8 (Neuronal Ceroid Lipofuscinosis), CPT2 (CPT II deficiency), FAH (Tyrosinemia), G6PC (GSD I), GAA (Pompe disease or GSD II), GALC (Krabbe disease), GALT (Galactosemia), GBA (Gaucher disease), HADHA (LCHAD), HEXA (Tay-Sachs disease), HGD (Alkaptonuria), MAN2B1 (Alpha-mannosidosis deficiency), NPC1 (Niemann-Pick C disease), NPC2 (Niemann-Pick C disease), PEX1 (Zellweger disease), PEX26 (Zellweger disease), PPT1 (Neuronal Ceroid Lipofuscinosis), PYGM (McArdle or GSD V disease) and SLC37A4 (GSD I)
- 0008 Noonan Syndrome and Other Genetically Related Syndromes**
(Noonan, Costello, LEPARD and Cardiofaciocutaneous) 80 mutations on genes: PTPN11, SOS1, RAF1, KRAS, MAP2K1, MAP2K, BRAF and HRAS
- 0009 Skeletal Dysplasia**
50 mutations on genes: FGFR3 (Achondroplasia and Thanatophoric Dysplasia), COL2A1 (Achondrogenesis type II), SLC26A2 (Achondrogenesis type IB), CRTAP (Osteogenesis Imperfecta recessive type), LEPRE1 (Osteogenesis Imperfecta recessive type), and SOX9 (Campomelic Dysplasia)
- 0010 Thrombophilia and Warfarin Pharmacogenetics**
15 mutations on genes: APOE Cys112Arg, APOE Arg158Cys, EPCR 4678G/C, Factor V Leiden Arg506Gln, Factor II G20210A, MTHFR C677T, MTHFR A1298C, PAI-1 4G/5G, PAI-1 -844 A>G, ACE Ins/Del, Beta-Fibrinogen -455G>A, Factor XIII Val34Leu, CYP2C9 and VKORC1]

Cardiology

Molecular Cytogenetics

- 3251** DiGeorge Syndrome
- 3252** Williams Syndrome

Endocrinology

Cytogenetics

- 3301** Chromosome analysis of stimulated cultures (peripheral blood)

Molecular Cytogenetics

- 3351** FISH analysis of sexual chromosomes (X/Y)

Reproductive Medicine

Cytogenetics

- 3401** Chromosome analysis of stimulated cultures (peripheral blood)

Obstetrics/Gyneconology

Cytogenetics

- 3451** Chromosome analysis of amniotic fluid
- 3452** Chromosome analysis of chorionic villi
- 3453** Chromosome analysis of stimulated cultures (peripheral blood)
- 3454** Chromosome analysis of stimulated cultures (fetal blood)
- 3455** Chromosome analysis of tissue fibroblasts
- 3456** Fibroblasts cell culture (amniotic fluid/chorionic villi)
- 3457** Fibroblasts cell culture (tissue)

Molecular Cytogenetics

Detection by FISH

- 3501** Aneuploidies on uncultured amniotic fluid
- 3502** Centromeric probes
- 3503** Comparative Genomic Hybridization (CGH) deletion/duplication analysis of the genome
- 3504** DiGeorge Syndrome
- 3505** Miller-Dieker Syndrome
- 3506** Painting probes
- 3507** Phelan-McDermid Syndrome
- 3508** Prader-Willi/Angelman Syndrome
- 3509** Smith-Magenis Syndrome
- 3510** Subtelomeric probes
- 3511** Unique sequence probes
- 3512** Williams Syndrome
- 3513** Wolf-Hirschhorn Syndrome
- 3514** Y chromosome microdeletions

Pediatrics/Clinical genetics

Cytogenetics

- 3551** Chromosome analysis of stimulated cultures (peripheral blood)
- 3552** Chromosome analysis of tissue fibroblasts
- 3553** Lymphocyte cell culture

Molecular Cytogenetics

- 3601** Comparative Genomic Hybridization (CGH) deletion/duplication analysis of the genome

Detection by FISH

- 3602** Centromeric probes
- 3603** DiGeorge Syndrome
- 3604** Miller-Dieker Syndrome
- 3605** Painting probes
- 3606** Phelan-McDermid Syndrome
- 3607** Prader-Willi/Angelman Syndrome sexual chromosomes (X/Y)
- 3608** Smith-Magenis Syndrome
- 3609** Subtelomeric probes subtelomeric rearrangements
- 3610** Unique sequence probes
- 3611** Williams Syndrome
- 3612** Wolf-Hirschhorn Syndrome

| Type of Analysis | Type of Sample | Amount |
|---|---|----------------------|
| CGC Mutation Panel | DNA | 500 ng |
| | Peripheral Blood – L | 3-5 mL |
| Molecular Diagnosis | DNA | 500 ng |
| | Peripheral Blood – L | 3-5 mL |
| Molecular Diagnosis (prenatal testing) | DNA from fetus + DNA from mother | 500 ng |
| | RNA | 1000 ng |
| Molecular Diagnosis (expression analysis) | Peripheral Blood (PAX gene tubes) | 3 mL |
| | Non stained cytogenetics slides | 3 slides per culture |
| Cytogenetics Analysis | Fixed cell suspension | 1 tube per culture |
| | Peripheral Blood (green top tube with Sodium Heparin) (for conventional karyotyping and FISH) | 3-5 mL |
| | | |

Shipping: Send specimen overnight at room temperature (must arrive less than 24 hrs after collection). Ship **Monday through Thursday** only.

Tube Type: L - Lavender top tube with EDTA

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