



MNG LABORATORIES
Neurogenetic Answers™

5424 Glenridge Drive NE
Atlanta, GA 30342 USA
toll-free: 678.225.0222
fax: 678.225.0212
mnglabs.com

**RNA Sequencing
Test Request Form**

We gladly accept deliveries Monday-Saturday, excluding holidays
CLIA License #11D0703390; CAP License #1441004; State of Georgia License #060-381

RNA Sequencing (2-4 week turnaround time)

IMPORTANT: Please contact MNG Laboratories prior to ordering RNA sequencing to avoid delay in sample processing*

MNG does NOT report cancer related genes

| | |
|--|--|
| MNG Comprehensive Transcriptome™ | <input type="checkbox"/> Full RNA sequencing |
| Panel Specific RNA Sequencing | <input type="checkbox"/> One Panel NGS Test Code: _____ |
| Gene Specific RNA Sequencing (list 1-5 genes) | <input type="checkbox"/> Up to 5 Genes _____ |

Patient and Specimen Information

| | |
|---|---|
| Patient Last Name | Patient First Name |
| Patient ID # | Date of Birth [MM/DD/YYYY] |
| Diagnosis/ICD-10 | Gender of Patient <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Was Patient Tested at MNG? <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, Specify Report Date [MM/DD/YYYY] |

Referring Physician Information

| | |
|---|---|
| Referring Physician Name | |
| Referring Physician NPI # [Required] Or international equivalent | |
| Facility / Organization | Phone |
| Select and Provide Email or Fax for Report Delivery | <input type="checkbox"/> Email <input type="checkbox"/> Fax |

[REQUIRED] Billing Information

| | |
|----------------------------------|-------|
| Facility Responsible for Payment | Phone |
| Facility Contact Person | Fax |
| Facility Contact Person Email | Email |
| Facility Billing Address | |
| City, State, Zip Code | |

Results (sent by secure HIPAA-compliant email or fax)

| | |
|---|---|
| Authorized Recipient Name | Authorized Recipient Name |
| Facility | Facility |
| Phone | Phone |
| <input type="checkbox"/> Fax <input type="checkbox"/> Email | <input type="checkbox"/> Fax <input type="checkbox"/> Email |

*RNA sequencing validated for muscle, whole blood, skin, and cell lines. Please call MNG prior to ordering RNA sequencing.



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Clinical Information Form

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Patient Name _____ **DOB** _____ **Gender** Male Female

Clinical (Check All That Apply)

| | | | |
|---|---|--|--|
| Eye <input type="checkbox"/> Retinitis Pigmentosa <input type="checkbox"/> Optic Atrophy <input type="checkbox"/> Other | Hearing <input type="checkbox"/> Sensorineural <input type="checkbox"/> Stickler <input type="checkbox"/> Usher | Neuronal Migration <input type="checkbox"/> Meckel <input type="checkbox"/> Joubert <input type="checkbox"/> Other | <input type="checkbox"/> Stroke |
| Cognitive/Neurobehavioral <input type="checkbox"/> Intellectual Disability (ID) <input type="checkbox"/> Syndromic ID <input type="checkbox"/> Nonsyndromic ID <input type="checkbox"/> Autism <input type="checkbox"/> Dementia | | | |
| Movement Disorders <input type="checkbox"/> Ataxia <input type="checkbox"/> Episodic Ataxia <input type="checkbox"/> Dystonia <input type="checkbox"/> Chorea/Athetosis <input type="checkbox"/> Parkinson Disease <input type="checkbox"/> L-Dopa Response | | | |
| Epilepsy <input type="checkbox"/> Myoclonic <input type="checkbox"/> Other <input type="checkbox"/> Absence <input type="checkbox"/> Tonic Clonic <input type="checkbox"/> Epileptic Encephalopathy | Spasticity <input type="checkbox"/> Spastic Paraplegia <input type="checkbox"/> Other <input type="checkbox"/> Spastic Quadriplegia | Connective Tissue & Bone <input type="checkbox"/> Ehlers Danlos <input type="checkbox"/> Marfan <input type="checkbox"/> Aneurysms <input type="checkbox"/> Other | |
| Neuromuscular <input type="checkbox"/> Distal <input type="checkbox"/> Proximal <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Contractures <input type="checkbox"/> Malignant Hyperthermia <input type="checkbox"/> Arthrogryposis <input type="checkbox"/> Rhabdomyolysis <input type="checkbox"/> Periodic Paralysis <input type="checkbox"/> Statin Use <input type="checkbox"/> Myasthenia | | Nerve/Anterior Horn Cell <input type="checkbox"/> Neurofibromas <input type="checkbox"/> Charcot-Marie-Tooth <input type="checkbox"/> Sensory <input type="checkbox"/> Autonomic <input type="checkbox"/> Pain <input type="checkbox"/> Motor <input type="checkbox"/> Nerve Conduction <input type="checkbox"/> Other | |
| Cardiomyopathy <input type="checkbox"/> Dilated <input type="checkbox"/> Hypertrophic <input type="checkbox"/> Noncompaction | Arrhythmias <input type="checkbox"/> Ventricular Tachycardia <input type="checkbox"/> Brugada <input type="checkbox"/> Long or Short QT <input type="checkbox"/> Conduction Defect | Congenital Heart Defects <input type="checkbox"/> Heterotaxy <input type="checkbox"/> Other | Endocrine <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Other <input type="checkbox"/> Diabetes Mellitus |

Additional Comments

Imaging (Check All That Apply)

Brain MRI
 Leigh Disease Basal Ganglia Calcification Stroke Cerebellar Atrophy Abnormal Myelin (describe) _____

EEG (Describe Findings)

EMG/NVC (Describe Findings)

Laboratory

| | |
|---|---|
| Metabolic (Describe Findings) _____ | Genetic (Describe Findings) _____ |
| CPK Maximum _____ Minimum _____ | <input type="checkbox"/> Chromosome Microarray <input type="checkbox"/> Deletion/Insertion Testing <input type="checkbox"/> Other (comment) |

Family History

| Affected Maternal Lineage | Affected Paternal Lineage | Siblings |
|---|--|---|
| Relationship to Proband | Relationship to Proband | Number (specify gender) |
| Symptoms | Symptoms | Healthy/Affected |
| Ethnicity (please check) | | |
| <input type="checkbox"/> South Asian <input type="checkbox"/> East Asian | <input type="checkbox"/> European (Non-Finnish) <input type="checkbox"/> European (Finnish) | <input type="checkbox"/> Latino <input type="checkbox"/> African <input type="checkbox"/> Other (comment) |



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**Informed Consent for
Genetic Testing**
In compliance with New York
State Civil Law: Section 79-L

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Please provide a copy of **completed** consent with sample and requisition. Failure to do so may delay testing.

When signed and dated, this written consent is written authorization to participate in genetic testing.

1. **Purpose of the Test:** My physician has explained the recommended testing: _____ (name of test or MNG test code), which is performed to help diagnose _____ (insert disease description).

I am aware that all documentation regarding this testing, including the description of the purpose, methodology, and disorders is freely available at www.mnglabs.com/tests and has either been reviewed with me by my physician or I have read the documentation on my own. **Patient (or parent/guardian) initials:** _____

2. **Statement Regarding Test Result:** A positive test result is an indication that the individual has a genetic cause for the specific disease tested for. A negative result may/may not rule out a genetic disorder depending on clinical history and quality/type of specimen tested. The individual may wish to consider further independent testing, consult a personal physician or pursue genetic counseling.
3. **Level of Certainty:** Is test-specific and determined by the methods employed, patient's clinical history and sometimes by the nature of the patient's condition at time of sampling. There is always a small possibility of error or failure in sample analysis; this is true with complex testing in any laboratory. Inclusion of clinical data, such as medical history, family history, images as they relate to the disease or disorder, will decrease the level of uncertainty in an interpretation and are encouraged to be included when submitting samples for analysis. MNG Laboratories will keep personal information private in accordance with HIPAA laws.

I consent to the retention of these documents by MNG Laboratories in their database.

Patient (or parent/guardian) Initials: _____

4. **Disclosing Test Results:** The following categories of persons or organizations that test results may be released to include, but are not limited to: hospitals or laboratories involved in the patient's care, referring physician(s) and primary care providers, other physician groups (consultants, surgeons), insurance companies (as provided by the patient or referring physician for payment purposes), and other professionals involved in patient care that assist MNG Laboratories in carrying out treatment, payment, and operational activities. Results are kept confidential. Medical Neurogenetics complies with security and privacy statutes of the federal Health Information Portability and Accountability Act (HIPAA). If a patient chooses to specifically declare where results may be released (other than the referring institution and ordering physician), please provide these *in writing* to the Compliance Officer, MNG Laboratories (quickresponse@mnglabs.com).
5. **Consent to Retain Specimen:** The laboratory does not return any remaining sample to individuals or physicians unless requested. No clinical tests other than those authorized shall be performed on the sample. A request for additional testing must be made by my referring physician or other authorized healthcare professional and there will be an additional charge. If agreed by the patient, MNG Laboratories will retain the samples for longer periods for use in an anonymous fashion for research/development or for quality assurance processes.

I consent to have my specimens retained after completion of initial testing (this consent may be withdrawn at any time and the laboratory will destroy any remaining sample). **Patient (or parent/guardian) Initials:** _____

6. **Testing for Genetic Conditions can be Complex:** If warranted, obtain professional genetic counseling prior to giving consent to fully understand what the risks and benefits are to having the testing completed. I hereby consent to participate in testing described above. I understand that a biologic specimen will be obtained from me and/or members of my family. I understand that this biologic specimen will be used for the purpose of attempting to determine if I, or members of my family, are affected or are carriers of a particular disease or are at increased risk to someday be affected with this genetic disease.

Signature of Patient

Date

Authorized Signature (Parent/Guardian)

Relationship

Name of Patient (please print clearly)

Name of Ordering MD (please print clearly)

Referring Facility (please print clearly)

Signature of Ordering MD

Important: One signature from patient (or parent/guardian), authorized person, or physician is required to complete this form. New York requires completion of all signatures on this form.