MNG LABORATORIES
Neurogenetic Answers™

5424 Glenridge Drive NE
Atlanta, GA 30342 USA
toll-free: 844.TESTMNG
fax: 678.225.0212
mnglabs.com

MNG Answers™ Test Request Form

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

Proband Information (REQUIRED for MNG Answers™)	
Proband Last Name	Proband First Name
MNG ID / ACCESSION #	Date of Birth [MM/DD/YYYY]
Gender ☐ Male ☐ Female	Date of Report [MM/DD/YYYY]

Negative MNG Exome™ Reflex to MNG Transcriptome™

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

- TAT 2-4 weeks, allow up to one week for processing and qualification

☐ MNG Transcriptome™ - Full RNA sequencing
☐ Gene Specific RNA Sequencing - Up to 5 Genes _____ _____ _____ _____ _____

Please complete page 2 with billing information and ordering physician details

Negative MNG Exome™ Reflex to MNGenome®

- TAT 2-6 weeks, allow up to one week for processing and qualification
- **Testing will not begin until all familial samples have been received**
- Consent forms must be included with familial samples

Please note if any samples will be shipped separately:

☐ MNGenome® - Trio Sequencing (Proband + 2 Family Members)
☐ MNGenome® - Proband Only Sequencing

Family Member 1 Information	
Last Name	First Name
Date of Birth [MM/DD/YYYY]	Date of Collection [MM/DD/YYYY]
Relationship to Proband	Gender ☐ Male ☐ Female
Affected? ☐ Yes ☐ No ☐ Unsure If yes, please include clinical information	Specimen Type ☐ Whole Blood ☐ Buccal Swab ☐ Tissue (specify source): _____ ☐ DNA (specify source): _____

Family Member 2 Information	
Last Name	First Name
Date of Birth [MM/DD/YYYY]	Date of Collection [MM/DD/YYYY]
Relationship to Proband	Gender ☐ Male ☐ Female
Affected? ☐ Yes ☐ No ☐ Unsure If yes, please include clinical information	Specimen Type ☐ Whole Blood ☐ Buccal Swab ☐ Tissue (specify source): _____ ☐ DNA (specify source): _____

Please complete page 2 with billing information and ordering physician details

MNG Use Only:

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Billing Information *(REQUIRED)*	
Self-Pay? ☐ Yes ☐ No	If yes, payer contact name & phone number:
Facility Responsible for Payment	Phone
Facility Contact Person	Email
Facility Billing Address 1	Fax
Facility Billing Address 2	
City, State, Zip Code	

Referring Physician Information		
Referring Physician Name	Print	Signature
Referring Physician **NPI # [Required]** or international equivalent		
Facility / Organization		Phone

Results (sent by secure HIPAA-compliant email or fax)	
Authorized Recipient Name	Authorized Recipient Name
Facility	Facility
Phone	Phone
☐ Fax ☐ Email	☐ Fax ☐ Email

Please include or attach any pertinent or additional clinical information: