MNG LABORATORIES
Neurogenetic Answers™

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

Known Familial Variant Test Request Form

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

☐ *MNG Variant Investigation Program (MNG VIP™)*

- Qualifying Variants Only
- No Charge Familial Testing

- VUS detected in a gene that causes disorders with dominant inheritance
- Two variants (VUS or Pathogenic/Likely Pathogenic) detected in a gene with recessive inheritance and phase (CIS vs TRANS) could not be determined from the sequencing data
- Up to two (2) immediate familial samples are accepted (parents or siblings)
- Updated report for proband only, indicating any classification change or carrier status
- **Testing will not begin until all familial samples have been received**
- TAT 2-4 weeks, allow up to one week for processing and qualification

Proband Information (REQUIRED for MNG VIP™ and MNG samples)	
Proband Last Name	Proband First Name
MNG ID / ACCESSION #	Date of Birth [MM/DD/YYYY]
Diagnosis/ICD-10	Gender ☐ Male ☐ Female

Please complete page 2 with family member/specimen details, variant details, and ordering physician information

☐ *Known Familial Variant Testing*

- Non-qualifying Variants
- Additional Family Members
- External Lab Samples

- Applies to SNVs, CNVs, and mtDNA variants identified through MNG Labs
- Applies to SNVs and mtDNA variants identified through external laboratories
- All individuals tested will receive a report
- Please include billing information below
- TAT 2-4 weeks

Proband Information (REQUIRED for MNG VIP™ and MNG samples)	
Proband Last Name	Proband First Name
MNG ID / ACCESSION #	Date of Birth [MM/DD/YYYY]
Diagnosis/ICD-10	Gender ☐ Male ☐ Female

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

Please complete page 2 with family member/specimen details, variant details, and ordering physician information

MNG Use Only:

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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): _____

Variant Information

Gene Name	Variant Details
Gene Name	Variant Details
Gene Name	Variant Details
Gene Name	Variant Details

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: