



**Proband Information (REQUIRED for MNG Answers™)**

Proband Last Name	Proband First Name
<b>MNG ID / ACCESSION #</b>	Date of Birth [MM/DD/YYYY]
Gender <input type="checkbox"/> Male <input type="checkbox"/> 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

<input type="checkbox"/> MNG Transcriptome™ - Full RNA sequencing
<input type="checkbox"/> 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:

<input type="checkbox"/> MNGenome® - Trio Sequencing (Proband + 2 Family Members)
<input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Affected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes, please attach clinical information	Specimen Type <input type="checkbox"/> Whole Blood <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Tissue (specify source): _____ <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Affected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes, please attach clinical information	Specimen Type <input type="checkbox"/> Whole Blood <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Tissue (specify source): _____ <input type="checkbox"/> DNA (specify source): _____

**Please complete page 2 with billing information and ordering physician details**

MNG Use Only:
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**MNG LABORATORIES**  
Neurogenetic Answers™

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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

**Billing Information (REQUIRED)**

Self-Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, <b>MUST</b> include payer contact name & details:	
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
<input type="checkbox"/> Fax <input type="checkbox"/> Email	<input type="checkbox"/> Fax <input type="checkbox"/> Email

**Please include or attach any pertinent or additional clinical information:**