



MNG LABORATORIES
Neurogenetic Answers™

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

**Custom
NGS Panel
Requisition Form**

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

Patient Name _____

DOB _____

Custom Gene Sequencing

IMPORTANT: READ BEFORE COMPLETING THIS SHEET

Please contact MNG Laboratories before sending in samples if submitting a Custom Next-Generation Sequencing Form for gene selection, options, and pricing.

www.mnglabs.com/support or 678.225.0222

Custom panels may have increased TAT due to system set up

Note: This form MUST accompany the Patient and Specimen Information Form.

Use HGNC gene designation for gene names.

Custom NGS Panel: \$1,795

Gene 1 _____

Gene 6 _____

Gene 2 _____

Gene 7 _____

Gene 3 _____

Gene 8 _____

Gene 4 _____

Gene 9 _____

Gene 5 _____

Gene 10 _____

Add-On Options Available

Repeat Expansions (select one or more)

C9orf72 Repeat Expansion (\$200)

HTT Repeat Expansion (\$200)

FRDA Repeat Expansion (\$200)

SCA Repeat Expansion (\$895)

(Includes SCA's 1, 2, 3, 6, 7, 8, 10, 12, 17, 36, & DRPLA)

mtDNA Sequencing + Deletion Analysis (\$200)

STAT <2 Weeks (\$500)

*STAT form **MUST** be completed and included*

PLEASE CHECK THE FOLLOWING BEFORE SUBMITTING:

I hereby acknowledge that I have spoken with a representative at MNG Laboratories regarding the gene/genes listed above and that this custom test has been approved for sequencing. I understand that failure to do so will delay my order.

I consent that the cost of a custom NGS panel with ten genes or less is \$1,795. I acknowledge that this price does not apply to custom NGS panels that require more than ten genes.

I fully understand that each add on is optional and that their associated costs will be added to the custom NGS panel.

Healthcare Provider Name: _____

Date: _____

Signature: _____



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Patient and Specimen Information Form

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Patient and Specimen Information			
Patient Last Name		Patient First Name	
Patient ID #		Date of Birth [MM/DD/YYYY]	
Diagnosis/ICD-10		Collection Date [MM/DD/YYYY]	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Specimen Type <input type="checkbox"/> Whole Blood <input type="checkbox"/> Buccal Swab	<input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Fibroblasts	<input type="checkbox"/> Skin [For Culture] <input type="checkbox"/> Plasma <input type="checkbox"/> Muscle <input type="checkbox"/> DNA Tissue: _____

Please complete and include our clinical information form, or attach clinical notes

Referring Physician Information	
Referring Physician Name	Print Signature
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

Billing Information (REQUIRED)	
Self-Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, MUST 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	

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

Forms Checklist
<p>All of the following are required before we will process your orders (please check the following):</p> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> All specimens that will be analyzed must be received <input type="checkbox"/> Clinical Information Form completed <input type="checkbox"/> Informed Consent for Genetic Testing completed and signed



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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

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"/> Chromosomal Microarray <input type="checkbox"/> Deletion/Insertion Testing <input type="checkbox"/> Other (comment)

Family History

Ethnicity (please check)

South Asian European (Non-Finnish) Latino Other (comment)
 East Asian European (Finnish) African

Affected Maternal Lineage	Affected Paternal Lineage	Siblings
Relationship to Proband	Relationship to Proband	Number (specify gender)
Symptoms	Symptoms	Healthy/Affected

Additional Comments



Informed Consent for Genetic Testing

In compliance with New York State Civil Law: Section 79-L

5424 Glenridge Drive NE | Atlanta, GA 30342 USA | phone: 844.TESTMNG | fax: 678.225.0212 | mnglabs.com

Patient Name _____ DOB _____

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 signatures from patient (or parent/guardian) AND ordering physician to complete this form.