MNG LABORATORIES
Neurogenetic Answers™

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

Patient and Specimen Information Form

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

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 ☐ Male ☐ Female

Specimen Type
☐ Whole Blood ☐ Buccal Swab ☐ CSF ☐ Urine ☐ Fibroblasts ☐ Skin [For Culture] ☐ Plasma ☐ Muscle ☐ 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	☐ Email ☐ Fax

Billing Information *(REQUIRED)*

Self-Pay? ☐ Yes ☐ 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
☐ Fax ☐ Email	☐ Fax ☐ Email

Forms Checklist

All of the following are required before we will process your orders (please check the following):

- ☐ All specimens that will be analyzed must be received
- ☐ Clinical Information Form completed
- ☐ Informed Consent for Genetic Testing completed and signed

MNG LABORATORIES
A LabCorp Company

Neurochemistry & Metabolic Test Request Form

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Patient Name _____ DOB _____

Metabolic

CSF

- ☐ (MET01) Amino Acids
- ☐ (MET07) Lactate
- ☐ (MET11) Pyruvate*
- ☐ (NC01) 5-Methyltetrahydrofolate
- ☐ (NC02) Neopterin [*Marker for CNS Immune System Stimulation*]
- ☐ (NC03) Neopterin/Tetrahydrobiopterin
- ☐ (NC04) Neurotransmitter Metabolites (5HIAA, HVA, 3OMD) [*Includes Biomarkers for Pyridoxine Responsive Seizures*]
- ☐ (NC05) Pyridoxal 5'-phosphate [*Pyridox[am]ine Phosphateoxidase Deficiency + CNS Pyridoxal 5'-phosphate Deficiency*]
- ☐ (NC06) Succinyladenosine [*Adenylosuccinate Lyase Deficiency*]
- ☐ (NC07) Sialic Acid [*Disorders with Hypomyelination of Unknown Etiology/ Sialic Acid Storage Disorders*]
- ☐ (NC08) Alpha-Aminoadipic Semialdehyde [*Pyridoxine-Responsive Seizures*]
- ☐ (NC10) Glucose [*Glucose Transporter Deficiency*]

Blood & Muscle

- ☐ (MET02) Amino acids (Plasma)
- ☐ (MET04) Coenzyme Q10 Level (Leukocytes)
- ☐ (MET05) Coenzyme Q10 Level (Muscle)
- ☐ (MET08) Lactate (Plasma)
- ☐ (MET09) Phenylalanine Loading Assay (Plasma)
- ☐ (MET10) Pyruvate* (Blood)

  ***requires deproteinization**
- ☐ (MET12) Thymidine/Deoxyuridine Analytes (Plasma)
- ☐ (MET23) Creatine & Guanidinoacetate (Plasma)
- ☐ (MET24) Glucose (Plasma)
- ☐ (MET29) 3-O-Methyldopa (Plasma) [*Specific Marker for Aromatic L-Amino Acid Decarboxylase Deficiency]*

Urine

- ☐ (MET03) Amino Acids
- ☐ (MET19) Creatine & Guanidinoacetate
- ☐ (MET20) Alpha Aminoadipic Semialdehyde [*Urine; for Pyridoxine-Responsive Seizures]*

Enzymology

Blood

- ☐ (ENZ01) Aromatic L-amino Acid Decarboxylase Enzyme Analysis (Plasma) - *STAT Not Available*
- ☐ (ENZ06) Thymidine Phosphorylase Enzyme Analysis (Blood) - *STAT Not Available*

Immunoassays

- ☐ (MET22) Folate Receptor Antibody Assay (Plasma/Serum) [*Cerebral Folate Deficiency*] - *STAT Not Available*
- ☐ (MET25) Folate Receptor Antibody Assay (CSF) [*Cerebral Folate Deficiency*] - *STAT Not Available*

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Clinical Information Form

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

Clinical (Check All That Apply)

Eye ☐ Retinitis Pigmentosa ☐ Optic Atrophy ☐ Other

Hearing ☐ Sensorineural ☐ Stickler ☐ Usher

Neuronal Migration ☐ Meckel ☐ Joubert ☐ Other

☐ Stroke

Cognitive/Neurobehavioral ☐ Intellectual Disability (ID) ☐ Syndromic ID ☐ Nonsyndromic ID ☐ Autism ☐ Dementia

Movement Disorders ☐ Ataxia ☐ Episodic Ataxia ☐ Dystonia ☐ Chorea/Athetosis ☐ Parkinson Disease ☐ L-Dopa Response

Epilepsy ☐ Myoclonic ☐ Other ☐ Absence ☐ Tonic Clonic ☐ Epileptic Encephalopathy

Spasticity ☐ Spastic Paraplegia ☐ Other ☐ Spastic Quadriplegia

Connective Tissue & Bone ☐ Ehlers Danlos ☐ Marfan ☐ Aneurysms ☐ Other

Neuromuscular ☐ Distal ☐ Proximal ☐ Muscle Atrophy ☐ Contractures ☐ Malignant Hyperthermia ☐ Arthrogryposis ☐ Rhabdomyolysis ☐ Periodic Paralysis ☐ Statin Use ☐ Myasthenia

Nerve/Anterior Horn Cell ☐ Neurofibromas ☐ Charcot-Marie-Tooth ☐ Sensory ☐ Autonomic ☐ Pain ☐ Motor ☐ Nerve Conduction ☐ Other

Cardiomyopathy ☐ Dilated ☐ Hypertrophic ☐ Noncompaction

Arrhythmias ☐ Ventricular Tachycardia ☐ Brugada ☐ Long or Short QT ☐ Conduction Defect

Congenital Heart Defects ☐ Heterotaxy ☐ Other

Endocrine ☐ Hypothyroidism ☐ Other ☐ 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)

CPK Maximum _____
Minimum _____

Genetic (Describe Findings)

☐ Chromosomal Microarray
☐ Deletion/Insertion Testing
☐ Other (comment)

Family History

Ethnicity (please check)

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

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

Additional Comments

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STAT Testing Request Form

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Patient Name _____ **DOB** _____

STAT Testing - Expedite Your Results

IMPORTANT: To request STAT Testing, STAT Testing Form must be ***completed, signed and submitted*** with test request form. Failure to do so will delay your order.

For a nominal fee, the following tests are available for STAT Testing:

Neurochemistry (NC) & Metabolic (MET) Tests	Molecular (MOL) Tests	Next-Generation Sequencing (NGS) Panels
$100 per test - 7 day TAT	**$200 per test - 2 week TAT**	**$500 per panel - 2 week TAT**

NOTE: All MNG tests rely heavily on our proprietary Genome MaNaGer® variant calling process coupled with our Neurogenetic Answers™ first-in-class reporting platform that delivers the actionable results you expect. MNG Laboratories will ensure any STAT orders meet the stated deadline, or the STAT fee will be waived.

Test Code

IMPORTANT: Enzymology tests NOT offered as STAT

Test Code: _____	**Test Code:** _____	**Test Code:** _____
Test Code: _____	**Test Code:** _____	**Test Code:** _____
Test Code: _____	**Test Code:** _____	**Test Code:** _____
Test Code: _____	**Test Code:** _____	**Test Code:** _____

Billing Information for STAT Testing *(REQUIRED)*

Self-Pay? ☐ Yes ☐ 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	

I HEREBY ACKNOWLEDGE *(check all & sign below)*:

☐ I acknowledge that the responsibile billing party listed above will pay for the additional costs associated with ordering a STAT Test. I understand that failure to submit payment for STAT Testing will delay my order.

☐ I consent that all requested STAT Tests listed above are either Neurochemistry tests, Metabolic tests, Molecular Tests or Next-Generation Sequencing Panels. I understand that all other tests are not available for STAT Testing and will not be ran as a STAT Test if requested.

Signature of Responsible Billing Party (*required*): _____

MNG LABORATORIES
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Informed Consent for Genetic Testing

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

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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.