



MNG LABORATORIES

A LabCorp Company

Custom Next-Generation Sequencing Test Request Form

5424 Glenridge Drive NE | Atlanta, GA 30342 USA | phone: 844.664.8378 | fax: 678.225.0212 | mnglabs.com

Patient Name _____

DOB _____

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/contact 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.

Custom Genes - Use HGNC Designation

Gene 1 _____

Gene 2 _____

Gene 3 _____

Gene 4 _____

Gene 5 _____

Gene 6 _____

Gene 7 _____

Gene 8 _____

Gene 9 _____

Gene 10 _____

Add-On Testing

The following assays are available as add-on tests. To add any of these to your order, please select from the following menu. List or contracted pricing will apply.

Mitochondrial DNA

mtDNA Sequencing + Deletion

Repeat Expansions (select one or more)

Huntington's disease (HTT)

C9orf72

Friedreich's Ataxia (FRDA)

Myotonic Dystrophy 1

Spinocerebellar Ataxia (SCAs)

Myotonic Dystrophy 2

Fragile X (FMR1 + Methylation)

RNA Sequencing (select one)

IMPORTANT: Please contact MNG prior to ordering RNA sequencing to avoid delays in sample processing. An additional sample is required.

MNG Transcriptome

Gene-Specific RNA Sequencing

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 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: _____



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"/> Plasma/Serum <input type="checkbox"/> DNA Tissue: _____ <input type="checkbox"/> Muscle

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

Referring Physician Information

Physician Name	NPI # or equivalent (Required)
Facility / Organization	Signature
Facility Address City, State, Zip Code	<input type="checkbox"/> Same as billing
Report Delivery <input type="checkbox"/> Fax	<input type="checkbox"/> Email Phone

Billing Information (REQUIRED)

Self-Pay? <input type="checkbox"/> Yes	If yes, MUST include payer contact name & details below. Payment must be received in full prior to testing.	
Facility	Contact Name	
Billing Address		
City, State, Zip Code		
Phone	Fax	Email

Results

Authorized Recipient Name	Phone	Authorized Recipient Name	Phone
<input type="checkbox"/> Fax		<input type="checkbox"/> Fax	
<input type="checkbox"/> Email		<input type="checkbox"/> Email	

Testing Checklist

All of the following are encouraged to be included with test orders (please check the following):

- All specimens that will be analyzed must be received - please note if samples will ship separately
- Clinical Information Form completed
- Informed Consent for Genetic Testing completed and signed



Clinical Information Form

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Patient Name _____ DOB _____

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** Intellectual Disability (ID) Syndromic ID Nonsyndromic ID Autism Dementia

- Movement Disorders** Ataxia Episodic Ataxia Dystonia Chorea/Athetosis Parkinson Disease 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"/> Arthrogyposis <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 | EEG (Describe Findings) | EMG/NVC (Describe Findings) |
| <input type="checkbox"/> Leigh Disease
<input type="checkbox"/> Basal Ganglia Calcification
<input type="checkbox"/> Stroke
<input type="checkbox"/> Cerebellar Atrophy
<input type="checkbox"/> Abnormal Myelin (describe) | | |

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)**
- Caucasian Sephardic Jewish African American (or Black) Asian
 Hispanic Ashkenazi Jewish Native American (or American Indian) Other: _____
- | | | |
|----------------------------------|----------------------------------|-------------------------|
| 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

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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) OR ordering physician to complete this form.