



Patient and Specimen Information Form

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

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		Authorized Recipient Name	
Facility		Facility	
Phone		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



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Patient Name _____

DOB _____

Metabolic

CSF

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

Blood & Muscle

- | | | |
|--|---|---|
| <input type="checkbox"/> (MET02) Amino Acids (Plasma) [†] | <input type="checkbox"/> (MET08) Lactate (Plasma) | <input type="checkbox"/> (MET23) Creatine & Guanidinoacetate (Plasma) |
| <input type="checkbox"/> (MET04) Coenzyme Q10 Level (Leukocytes) | <input type="checkbox"/> (MET09) Phenylalanine Loading Assay (Plasma) | <input type="checkbox"/> (MET24) Glucose (Plasma) |
| <input type="checkbox"/> (MET05) Coenzyme Q10 Level (Muscle) | <input type="checkbox"/> (MET10) Pyruvate* (Blood) | <input type="checkbox"/> (MET29) 3-O-Methyldopa (Plasma) [Specific Marker for Aromatic L-Amino Acid Decarboxylase Deficiency] |
| | <input type="checkbox"/> (MET12) Thymidine/Deoxyuridine Analytes (Plasma) | |

Urine

- | | | |
|---|--|--|
| <input type="checkbox"/> (MET03) Amino Acids [†] | <input type="checkbox"/> (MET19) Creatine & Guanidinoacetate | <input type="checkbox"/> (MET20) Alpha Amino adipic Semialdehyde [Urine; for Pyridoxine-Responsive Seizures] |
|---|--|--|

Enzymology

Blood

- | | |
|---|--|
| <input type="checkbox"/> (ENZ01) Aromatic L-amino Acid Decarboxylase Enzyme Analysis (Plasma) - STAT Not Available | <input type="checkbox"/> (ENZ06) Thymidine Phosphorylase Enzyme Analysis (Blood) - STAT Not Available |
|---|--|

[†] Denotes testing performed at LabCorp, Burlington, NC - **STAT Not Available**

*Denotes testing requires deproteinization



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"/> Malignant Hyperthermia <input type="checkbox"/> Arthrogyposis
<input type="checkbox"/> Periodic Paralysis <input type="checkbox"/> Statin Use | <input type="checkbox"/> Contractures
<input type="checkbox"/> Rhabdomyolysis
<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
<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) | EEG (Describe Findings)
_____ | EMG/NVC (Describe Findings)
_____ |
|---|---|---|

Laboratory

- | | |
|---|---|
| Metabolic (Describe Findings)

CPK Maximum _____
Minimum _____ | Genetic (Describe Findings)

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

Family History

- Ethnicity (please check)**
- | | | | |
|------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> Sephardic Jewish | <input type="checkbox"/> African American (or Black) | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Native American (or American Indian) | <input type="checkbox"/> Other: _____ |
- | | | |
|----------------------------------|----------------------------------|-------------------------|
| Affected Maternal Lineage | Affected Paternal Lineage | Siblings |
| Relationship to Proband | Relationship to Proband | Number (specify gender) |
| Symptoms | Symptoms | Healthy/Affected |

Additional Comments



STAT Test 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 an additional fee, the following tests are available for STAT Testing:

Neurochemistry (NC) & Metabolic (MET) Tests 7 day TAT	Molecular (MOL) Tests 2 week TAT	Next-Generation Sequencing (NGS) Panels 2 week TAT
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NOTE: MNG Laboratories will ensure any STAT orders meet the stated deadline, or the STAT fee will be waived.

Patient and Specimen Information

Patient Last Name	Patient First Name
Patient ID #	Date of Birth [MM/DD/YYYY]

Test Code

IMPORTANT: Enzymology, familial variants, and RNA tests NOT available 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 (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

I HEREBY ACKNOWLEDGE (check all & sign below):

- I acknowledge that the responsible 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): _____