



CLIA ID: 45D2332030
Lab Director: Dr. Congying Gu

HEREDITARY EYE DISORDERS RISK TESTING REQUISITION FORM

INSTRUCTIONS

- Patient and Physician must sign the consent form
- All items identified as '**Required**' must be Provided/attached to the requisition form.

SUBMISSION CHECKLIST

- ☐ SOAP notes and progress notes
- ☐ Patient insurance ID card or face sheet
- ☐ Physician and Patient Signature

ORDERING PHYSICIAN INFORMATION

Physician Name	NPI#	FAX#
Office/Practice/Institution Name		Physician's Email
Street Address		
City	State	Zip Code
Office Contact Name	Contact Phone	Contact Email

Ordering Provider (Please select one physician per order)

Physician name:	Physician NPI:	Physician name:	Physician NPI:
Physician name:	Physician NPI:	Physician name:	Physician NPI:

PATIENT INFORMATION

REQUIRED

Patient First Name	Patient Last Name	Date of Birth (mm/dd/yyyy)	Phone Number
Address		City	State Zip

Gender Identity

- ☐ Male
- ☐ Female
- ☐ Female-to-Male
- ☐ Male-to-Female
- ☐ Gender queer
- ☐ Other (Specify)
- ☐ Choose not to Disclose

Sexual Orientation

- ☐ Lesbian, gay, or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else (Describe)
- ☐ Choose not to disclose

Ancestry

- ☐ White/Caucasian
- ☐ Native American
- ☐ Hispanic
- ☐ African American
- ☐ Ashkenazi Jewish
- ☐ Middle eastern
- ☐ American Indian
- ☐ Asian
- ☐ Native Hawaiian and Other Pacific Islander

PAYMENT OPTIONS(SELECT ONE)

REQUIRED

<input type="checkbox"/> Insurance Billing (Please provide the insurance information) <input type="checkbox"/> Self-Pay (Please provide credit card details or mail the check to the laboratory address) <input type="checkbox"/> Client Billing / Institutional Billing	Primary Insurance	Insurance Policy/ID#	Group#
	Primary Policy Holder Name	Date of Birth	
	Secondary Insurance	Insurance Policy/ID#	Group#
	Secondary Policy Holder Name	Date of Birth	

SPECIMEN INFORMATION

REQUIRED

Sample Type <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Extracted DNA Sample Draw Date (mm/dd/yyyy)/...../.....	Shipping Instructions <ul style="list-style-type: none">■ Label each specimen tube with the patient's full name and date of birth or patient's full name and collection date.■ To receive the specimen requirements and shipping guidelines, please send an email to - clientservices@preventivegx.com	Send completed Requisition Form with collected sample to: 10700 Richmond Ave, STE 112 Houston, TX 77042
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CLINICAL HISTORY

Indications for Testing: ☐ Diagnostic ☐ Presymptomatic ☐ Family History ☐ Family Variant ☐ Other:

Age of Primary Diagnosis:

Previous genetic tests: ☐ Yes ☐ No
(If Yes, please specify the test and results)

Will Patient management be changed depending on the test results? ☐ Yes ☐ No

Is this person affected? ☐ Yes ☐ No

☐ Unilateral ☐ Bilateral

Intraocular Pressure: **ERG Results :**

Please check all that apply.

Eye/Vision Abnormalities

- | | | | | | |
|--|---|--|--|---|--|
| <input type="checkbox"/> Abnormality of vision | <input type="checkbox"/> Cataracts | <input type="checkbox"/> External ophthalmoplegia | <input type="checkbox"/> Microphthalmia | <input type="checkbox"/> Photophobia | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Aniridia | <input type="checkbox"/> Coloboma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Myopia | <input type="checkbox"/> Ptosis | |
| <input type="checkbox"/> Anophthalmia | <input type="checkbox"/> Corneal arcus | <input type="checkbox"/> Hyperopia | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Retinal detachment | |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Ectopia lentis | <input type="checkbox"/> Hypoplasia of the fovea | <input type="checkbox"/> Nystagmus | <input type="checkbox"/> Retinitis pigmentosa | |
| <input type="checkbox"/> Blue sclerae | <input type="checkbox"/> Esotropia | <input type="checkbox"/> Keratoconus/anterior lenticonus | <input type="checkbox"/> Optic atrophy | <input type="checkbox"/> Strabismus | |

FAMILY HISTORY								
<input type="checkbox"/> No Known Family History		<input type="checkbox"/> Pedigree Attached		<input type="checkbox"/> Adopted				
Relationship	Maternal	Paternal	Relevant History		Age at Diagnosis			
1	<input type="checkbox"/>	<input type="checkbox"/>						
2	<input type="checkbox"/>	<input type="checkbox"/>						
3	<input type="checkbox"/>	<input type="checkbox"/>						
CUSTOM PANEL (SELECT GENES) OR <input checked="" type="checkbox"/> COMPREHENSIVE PANEL					REQUIRED			
<input type="checkbox"/> ABCA4	<input type="checkbox"/> CDKL5	<input type="checkbox"/> CTSD	<input type="checkbox"/> GPR98	<input type="checkbox"/> NR2E3	<input type="checkbox"/> PDE6B	<input type="checkbox"/> RPE65	<input type="checkbox"/> SLC9A6	<input type="checkbox"/> TSC2
<input type="checkbox"/> ALDH7A1	<input type="checkbox"/> CDKN2B-AS	<input type="checkbox"/> CYP1B1	<input type="checkbox"/> GRIN2A	<input type="checkbox"/> NRL	<input type="checkbox"/> PITX2	<input type="checkbox"/> RPGR	<input type="checkbox"/> STXBPI	<input type="checkbox"/> USH1C
<input type="checkbox"/> ATXN7	<input type="checkbox"/> CFH	<input type="checkbox"/> EYS	<input type="checkbox"/> HSF4	<input type="checkbox"/> OPN1LW	<input type="checkbox"/> POLG	<input type="checkbox"/> SCN1A	<input type="checkbox"/> SYNGAP1	<input type="checkbox"/> USH1G
<input type="checkbox"/> BEST1	<input type="checkbox"/> CHD2	<input type="checkbox"/> FOXC1	<input type="checkbox"/> KCNQ2	<input type="checkbox"/> OPN1MW	<input type="checkbox"/> PRPF31	<input type="checkbox"/> SCN1B	<input type="checkbox"/> TCF4	<input type="checkbox"/> USH2A
<input type="checkbox"/> BFSP1	<input type="checkbox"/> CLRN1	<input type="checkbox"/> FOXE3	<input type="checkbox"/> LTBP2	<input type="checkbox"/> OTOF	<input type="checkbox"/> PRPH2	<input type="checkbox"/> SCN2A	<input type="checkbox"/> TGFB1	<input type="checkbox"/> WFS1
<input type="checkbox"/> BFSP2	<input type="checkbox"/> CNGA1	<input type="checkbox"/> FTL	<input type="checkbox"/> MECP2	<input type="checkbox"/> PAX2	<input type="checkbox"/> PRRT2	<input type="checkbox"/> SCN8A	<input type="checkbox"/> TMC1	<input type="checkbox"/> ZEB2
<input type="checkbox"/> CACNA1A	<input type="checkbox"/> CRB1	<input type="checkbox"/> GABRG2	<input type="checkbox"/> MTRNR1	<input type="checkbox"/> PAX6	<input type="checkbox"/> RDH12	<input type="checkbox"/> SIX1	<input type="checkbox"/> TMC01	
<input type="checkbox"/> CAV1	<input type="checkbox"/> CRYAA	<input type="checkbox"/> GALK1	<input type="checkbox"/> MYO15A	<input type="checkbox"/> PCDH15	<input type="checkbox"/> RHO	<input type="checkbox"/> SIX6	<input type="checkbox"/> TMPRSS3	
<input type="checkbox"/> CAV2	<input type="checkbox"/> CRYAB	<input type="checkbox"/> GJB2	<input type="checkbox"/> MYO7A	<input type="checkbox"/> PCDH19	<input type="checkbox"/> RP1	<input type="checkbox"/> SLC26A4	<input type="checkbox"/> TPP1	
<input type="checkbox"/> CDH23	<input type="checkbox"/> CRYGC	<input type="checkbox"/> GJB6	<input type="checkbox"/> MYOC	<input type="checkbox"/> PDE6A	<input type="checkbox"/> RP2	<input type="checkbox"/> SLC2A1	<input type="checkbox"/> TSC1	
COMMONLY USED ICD10 (DIAGNOSIS) CODES								
Please note, the icd-10 codes herein are solely for informational use. It is incumbent upon order practitioners to the diagnosis code that precisely justifies test conduct, regardless of its presence in the subsequent list.								
Category - 1: ICD10 codes								
<input type="checkbox"/> B73.1 Onchocerciasis without eye disease	<input type="checkbox"/> E10.3599 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye							
<input type="checkbox"/> C43.10 Malignant melanoma of unspecified eyelid, including canthus	<input type="checkbox"/> E11.3211 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye							
<input type="checkbox"/> C4A.10 Merkel cell carcinoma of unspecified eyelid, including canthus	<input type="checkbox"/> E11.3212 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye							
<input type="checkbox"/> C69.00 Malignant neoplasm of unspecified conjunctiva	<input type="checkbox"/> E11.3219 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye							
<input type="checkbox"/> C69.01 Malignant neoplasm of right conjunctiva	<input type="checkbox"/> E11.3291 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye							
<input type="checkbox"/> C69.02 Malignant neoplasm of left conjunctiva	<input type="checkbox"/> E11.3292 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye							
<input type="checkbox"/> C69.10 Malignant neoplasm of unspecified cornea	<input type="checkbox"/> E11.3299 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye							
<input type="checkbox"/> C69.11 Malignant neoplasm of right cornea	<input type="checkbox"/> E11.3311 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye							
<input type="checkbox"/> C69.12 Malignant neoplasm of left cornea	<input type="checkbox"/> E11.3312 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye							
<input type="checkbox"/> C69.20 Malignant neoplasm of unspecified retina	<input type="checkbox"/> E11.3319 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye							
<input type="checkbox"/> C69.21 Malignant neoplasm of right retina	<input type="checkbox"/> E11.3391 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye							
<input type="checkbox"/> C69.22 Malignant neoplasm of left retina	<input type="checkbox"/> E11.3392 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye							
<input type="checkbox"/> C69.30 Malignant neoplasm of unspecified choroid	<input type="checkbox"/> E11.3399 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye							
<input type="checkbox"/> C69.31 Malignant neoplasm of right choroid	<input type="checkbox"/> E11.3411 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macularedema, right eye							
<input type="checkbox"/> C69.32 Malignant neoplasm of left choroid	<input type="checkbox"/> E11.3412 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye							
<input type="checkbox"/> C69.40 Malignant neoplasm of unspecified ciliary body	<input type="checkbox"/> E11.3419 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye							
<input type="checkbox"/> C69.41 Malignant neoplasm of right ciliary body	<input type="checkbox"/> E11.3491 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye							
<input type="checkbox"/> C69.42 Malignant neoplasm of left ciliary body	<input type="checkbox"/> E11.3492 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye							
<input type="checkbox"/> C69.50 Malignant neoplasm of unspecified lacrimal gland and duct	<input type="checkbox"/> E11.3499 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye							
<input type="checkbox"/> C69.51 Malignant neoplasm of right lacrimal gland and duct	<input type="checkbox"/> H01.121 Discoid lupus erythematosus of right upper eyelid							
<input type="checkbox"/> C69.52 Malignant neoplasm of left lacrimal gland and duct	<input type="checkbox"/> H01.122 Discoid lupus erythematosus of right lower eyelid							
<input type="checkbox"/> C69.60 Malignant neoplasm of unspecified orbit	<input type="checkbox"/> H01.123 Discoid lupus erythematosus of right eye, unspecified eyelid							
<input type="checkbox"/> C69.61 Malignant neoplasm of right orbit	<input type="checkbox"/> H01.124 Discoid lupus erythematosus of left upper eyelid							
<input type="checkbox"/> C69.62 Malignant neoplasm of left orbit	<input type="checkbox"/> H01.125 Discoid lupus erythematosus of left lower eyelid							
<input type="checkbox"/> C69.80 Malignant neoplasm of overlapping sites of unspecified eye and adnexa	<input type="checkbox"/> H01.126 Discoid lupus erythematosus of left eye, unspecified eyelid							
<input type="checkbox"/> C69.81 Malignant neoplasm of overlapping sites of right eye and adnexa	<input type="checkbox"/> H01.129 Discoid lupus erythematosus of unspecified eye, unspecified eyelid							
<input type="checkbox"/> C69.82 Malignant neoplasm of overlapping sites of left eye and adnexa	<input type="checkbox"/> H01.131 Eczematous dermatitis of right upper eyelid							
<input type="checkbox"/> C69.90 Malignant neoplasm of unspecified site of unspecified eye	<input type="checkbox"/> H01.132 Eczematous dermatitis of right lower eyelid							
<input type="checkbox"/> C69.91 Malignant neoplasm of unspecified site of right eye	<input type="checkbox"/> H01.133 Eczematous dermatitis of right eye, unspecified eyelid							
<input type="checkbox"/> C69.92 Malignant neoplasm of unspecified site of left eye	<input type="checkbox"/> H01.134 Eczematous dermatitis of left upper eyelid							
<input type="checkbox"/> D31.90 Benign neoplasm of unspecified part of unspecified eye	<input type="checkbox"/> H01.135 Eczematous dermatitis of left lower eyelid							
<input type="checkbox"/> D31.91 Benign neoplasm of unspecified part of right eye	<input type="checkbox"/> H01.136 Eczematous dermatitis of left eye, unspecified eyelid							
<input type="checkbox"/> D31.92 Benign neoplasm of unspecified part of left eye	<input type="checkbox"/> H01.139 Eczematous dermatitis of unspecified eye, unspecified eyelid							
<input type="checkbox"/> E10.3211 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macularedema, right eye	<input type="checkbox"/> H01.141 Xeroderma of right upper eyelid							
<input type="checkbox"/> E10.3212 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macularedema, left eye	<input type="checkbox"/> H01.142 Xeroderma of right lower eyelid							
<input type="checkbox"/> E10.3219 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macularedema, unspecified eye	<input type="checkbox"/> H01.143 Xeroderma of right eye, unspecified eyelid							
<input type="checkbox"/> E10.3291 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	<input type="checkbox"/> H01.144 Xeroderma of left upper eyelid							
<input type="checkbox"/> E10.3292 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macula edema, left eye	<input type="checkbox"/> H01.145 Xeroderma of left lower eyelid							
<input type="checkbox"/> E10.3299 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	<input type="checkbox"/> H01.146 Xeroderma of left eye, unspecified eyelid							
<input type="checkbox"/> E10.3311 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	<input type="checkbox"/> H01.149 Xeroderma of unspecified eye, unspecified eyelid							
<input type="checkbox"/> E10.3312 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye								
<input type="checkbox"/> E10.3313 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral								
<input type="checkbox"/> E10.3319 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye								
<input type="checkbox"/> E10.3391 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye								
<input type="checkbox"/> E10.3392 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye								
<input type="checkbox"/> E10.3399 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye								
Continued								

<input type="checkbox"/> E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	<input type="checkbox"/> H01.8	Other specified inflammations of eyelid
<input type="checkbox"/> E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	<input type="checkbox"/> H01.9	Unspecified inflammation of eyelid
<input type="checkbox"/> E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	<input type="checkbox"/> H40.001	Preglaucoma, unspecified, right eye
<input type="checkbox"/> E10.3419	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	<input type="checkbox"/> H40.002	Preglaucoma, unspecified, left eye
<input type="checkbox"/> E10.3491	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	<input type="checkbox"/> H40.009	Preglaucoma, unspecified, unspecified eye
<input type="checkbox"/> E10.3492	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	<input type="checkbox"/> H40.011	Open angle with borderline findings, low risk, right eye
<input type="checkbox"/> E10.3499	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	<input type="checkbox"/> H40.012	Open angle with borderline findings, low risk, left eye
<input type="checkbox"/> E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	<input type="checkbox"/> H40.019	Open angle with borderline findings, low risk, unspecified eye
<input type="checkbox"/> E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	<input type="checkbox"/> H40.021	Open angle with borderline findings, high risk, right eye
<input type="checkbox"/> E10.3519	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	<input type="checkbox"/> H40.022	Open angle with borderline findings, high risk, left eye
<input type="checkbox"/> E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macular edema, right eye	<input type="checkbox"/> H40.029	Open angle with borderline findings, high risk, unspecified eye
<input type="checkbox"/> E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macular edema, left eye	<input type="checkbox"/> H40.031	Anatomical narrow angle, right eye
<input type="checkbox"/> E10.3529	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macular edema, unspecified eye	<input type="checkbox"/> H40.032	Anatomical narrow angle, left eye
<input type="checkbox"/> E10.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	<input type="checkbox"/> H40.039	Anatomical narrow angle, unspecified eye
<input type="checkbox"/> E10.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	<input type="checkbox"/> H40.051	Ocular hypertension, right eye
<input type="checkbox"/> E10.3539	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula [unspecified eye]	<input type="checkbox"/> H40.059	Ocular hypertension, unspecified eye
<input type="checkbox"/> E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	<input type="checkbox"/> H40.061	Primary angle closure without glaucoma damage, right eye
<input type="checkbox"/> E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	<input type="checkbox"/> H40.062	Primary angle closure without glaucoma damage, left eye
<input type="checkbox"/> E10.3549	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment	<input type="checkbox"/> H40.069	Primary angle closure without glaucoma damage, unspecified eye
<input type="checkbox"/> E10.3551	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye	<input type="checkbox"/> H40.811	Glaucoma with increased episcleral venous pressure, right eye
<input type="checkbox"/> E10.3552	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye	<input type="checkbox"/> H40.812	Glaucoma with increased episcleral venous pressure, left eye
<input type="checkbox"/> E10.3553	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	<input type="checkbox"/> H40.819	Glaucoma with increased episcleral venous pressure, unspecified eye
<input type="checkbox"/> E10.3559	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	<input type="checkbox"/> H40.821	Hypersecretion glaucoma, right eye
<input type="checkbox"/> E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	<input type="checkbox"/> H40.822	Hypersecretion glaucoma, left eye
<input type="checkbox"/> E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	<input type="checkbox"/> H40.829	Hypersecretion glaucoma, unspecified eye
<input type="checkbox"/> H40.052	Ocular hypertension, left eye	<input type="checkbox"/> H40.89	Other specified glaucoma
<input type="checkbox"/> H40.053	Ocular hypertension, bilateral	<input type="checkbox"/> H46.00	Optic papillitis, unspecified eye
<input type="checkbox"/> H52.4	Presbyopia	<input type="checkbox"/> H46.01	Optic papillitis, right eye
<input type="checkbox"/> H47.22	Hereditary optic atrophy	<input type="checkbox"/> H46.02	Optic papillitis, left eye
<input type="checkbox"/> H35.30	Unspecified macular degeneration	<input type="checkbox"/> H46.10	Retrobulbar neuritis, unspecified eye
		<input type="checkbox"/> H46.11	Retrobulbar neuritis, right eye
		<input type="checkbox"/> H46.12	Retrobulbar neuritis, left eye
		<input type="checkbox"/> H57.00	Unspecified anomaly of pupillary function
		<input type="checkbox"/> H57.01	Argyll Robertson pupil, atypical
		<input type="checkbox"/> H57.02	Anisocoria
		<input type="checkbox"/> H57.03	Miosis
		<input type="checkbox"/> H57.04	Mydriasis
		<input type="checkbox"/> H57.051	Tonic pupil, right eye
		<input type="checkbox"/> H57.052	Tonic pupil, left eye
		<input type="checkbox"/> H57.053	Tonic pupil, bilateral
		<input type="checkbox"/> H57.059	Tonic pupil, unspecified eye
		<input type="checkbox"/> H57.09	Other anomalies of pupillary function
		<input type="checkbox"/> Z13.5	Encounter for screening for eye and ear disorders
		<input type="checkbox"/> Z83.51	Family history of eye disorders
		<input type="checkbox"/> Z85.84	Personal history of malignant neoplasm of eye and nervous tissue
		<input type="checkbox"/> Z86.69	Personal history of other diseases of the nervous system and sense organs
		<input type="checkbox"/> H35.50	Unspecified hereditary retinal dystrophy
		<input type="checkbox"/> H35.51	Vitreoretinal dystrophy
		<input type="checkbox"/> H35.52	Pigmentary retinal dystrophy
		<input type="checkbox"/> H35.53	Other dystrophies primarily involving the sensory retina
		<input type="checkbox"/> H35.54	Dystrophies primarily involving the retinal pigment epithelium
		<input type="checkbox"/> H11.89	Other specified disorders of conjunctiva
		<input type="checkbox"/> H52.10	Myopia, unspecified eye
		<input type="checkbox"/> H52.201	Unspecified astigmatism, right eye
		<input type="checkbox"/> H18.9	Unspecified disorder of cornea
		<input type="checkbox"/> H18.9	Choroideremia
		<input type="checkbox"/> H04.301	Unspecified dacryocystitis of right lacrimal passage
		<input type="checkbox"/> H04.122	Dry eye syndrome of left lacrimal gland
		<input type="checkbox"/> H40.9	Unspecified glaucoma

Category - 2: ICD10 codes

<input type="checkbox"/> T41.OX5A – Adverse effect of inhaled anesthetics, initial encounter	<input type="checkbox"/> T41.IX5A – Adverse effect of intravenous anesthetics, initial encounter
<input type="checkbox"/> T41.OX5D – Adverse effect of inhaled anesthetics, subsequent encounter	<input type="checkbox"/> T41.IX5D – Adverse effect of intravenous anesthetics, subsequent encounter
<input type="checkbox"/> T41.OX5S – Adverse effect of inhaled anesthetics, sequela	<input type="checkbox"/> T41.IX5S – Adverse effect of intravenous anesthetics, sequela
<input type="checkbox"/> T41.OX6A – Underdosing of inhaled anesthetics, initial encounter	<input type="checkbox"/> T41.IX6A – Underdosing of intravenous anesthetics, initial encounter
<input type="checkbox"/> T41.OX6D – Underdosing of inhaled anesthetics, subsequent encounter	<input type="checkbox"/> T41.IX6D – Underdosing of intravenous anesthetics, subsequent encounter
<input type="checkbox"/> T41.OX6S – Underdosing of inhaled anesthetics, sequela	<input type="checkbox"/> T41.IX6S – Underdosing of intravenous anesthetics, sequela

Additional ICD10 Codes:

PATIENT CONSENT

REQUIRED

By signing this form, I acknowledge that the information provided by me is true and correct. I have read, or have had read to me, the Preventive Genomics Informed Consent document at the end of this test requisition form and understand the information regarding molecular genetics testing. For direct insurance billing: I authorize my insurance benefits to be paid directly to Preventive Genomics and their affiliates. I authorize Preventive Genomics to release medical information concerning my testing to my insurer, to act as my designated representative for the purpose of appealing any denial of benefits as needed, and to request additional medical records for this purpose. I understand that I am financially responsible for any amounts not covered by my insurer and responsible for sending Preventive Genomics and their affiliates any money received from my health insurance company. I also give permission for my specimen and clinical information to be used in de-identified studies at Preventive Genomics and their affiliates for publication, if appropriate. I have had the opportunity to ask questions about the testing, the procedure, the risks, and the alternatives. I authorize Preventive Genomics and their affiliates to perform the testing as ordered.

Signature

Date _____

CERTIFICATE OF MEDICAL NECESSITY, CONSENT, TEST AUTHORIZATION AND PHYSICIAN SIGNATURE

REQUIRED

The individual signing this form, or their representative, hereby confirms their status as a licensed medical professional authorized to order genetic testing and confirms that the patient has provided informed consent for the testing and that it is medically necessary. They certify that any custom panel and/or ordered test(s) requested on this test requisition form are reasonable and medically necessary for the diagnosis and/or treatment of a disease, illness, impairment, symptom, syndrome, or disorder. They acknowledge that the test results may have an impact on the patient's medical management. The information provided on this form is accurate to the best of their knowledge. The signature on this form applies to the attached letter of medical necessity. If the insurance provider requests the laboratory to gather the medical necessity for any reason, the signer agrees to provide the Care Plan notes and Letter of Intent for this order.

Signature

Date

INFORMED CONSENT

For the purposes of this consent, “I”, “my”, and “your” will refer to me or to my child, including my unborn child, if my child is the person for whom the healthcare provider has ordered testing.

PURPOSE OF THIS TEST

The purpose of this test is (a) to see if I may have a genetic variant or chromosome rearrangement causing a genetic disorder; or (b) to evaluate the chance that I will develop or pass on a genetic disorder in the future. If I already know the specific gene variant(s) or chromosome rearrangement that causes the genetic disorder in my family, I agree to inform the laboratory of this information.

WHAT TYPE OF TEST RESULTS CAN I EXPECT FROM GENETIC TESTING?

1. Positive: A change in your DNA was found, which is very likely the cause of your features/symptoms. This is the most straightforward test result, which can be used as the basis to test other family members to determine their chances of having either the disease or a child with the disease.
2. Negative: No variants were found to explain your symptoms. This does not mean that you do not have a genetic condition. It is still possible that there is a genetic variant not found by the test that was ordered. Your healthcare provider or genetic counselor may discuss more testing either now or in the future.
3. Variant of Uncertain Significance (VUS): A change in a gene was found. However, we are not sure whether this variant is the cause of your symptoms/features. More information is needed. We may suggest testing other family members to help figure out the meaning of the test result.
4. Unexpected Results: In rare instances, this test may reveal an important genetic change that is not directly related to the reason for ordering this test. For example, this test may find you are at risk for another genetic condition I am not aware of or it may indicate differences in the number or rearrangement of sex chromosomes.

We may disclose this information to the ordering healthcare provider if it likely affects medical care.

Because medical and scientific knowledge is constantly changing, new information that becomes available may supplement the information Preventive Genomics used to interpret my results. Healthcare providers can contact Preventive Genomics at any time to discuss the classification of an identified variant.

WHAT IS TRIO/DUO-BASED GENETIC TESTING?

For some genetic tests, including samples from the biological parents and/or other biological relatives along with the patient's sample can help with the interpretation of the test results. These tests are often referred to as “trio tests” since they typically include samples from the patient and both parents. Samples from relatives should be submitted with the patient's sample. Clinical information must be provided for the patient and any relative who submits a sample.

I understand that Preventive Genomics will use the relative sample(s) when needed for the interpretation of my test results and that my test report may include clinical and genetic information about a relative when it is relevant to the interpretation of the test results. I further understand that relatives will not receive an independent analysis of data nor a separate report.

RISKS AND LIMITATIONS OF GENETIC TESTING

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1. In some cases, testing may not identify a genetic variant even though one exists. This may be due to limitations in current medical knowledge or testing technology.
2. Accurate interpretation of test results may require knowing the true biological relationships in a family. I understand that if I fail to accurately state the biological relationships in my family, it could lead to incorrect interpretation of the test results, incorrect diagnoses, and/or inconclusive test results. If genetic testing reveals that the true biological relationships in a family are not as I reported them, including non-paternity (the reported father is not the biological father) and consanguinity (the parents are related by blood), I agree to have these findings reported to the healthcare provider who ordered the test.
3. Although genetic testing is highly accurate, inaccurate results may occur. These reasons include, but are not limited to mislabeled samples, inaccurate reporting of clinical/medical information, rare technical errors, or other reasons.
4. I understand that this test may not detect all of the long-term medical risks that I might experience. The result of this test does not guarantee my health and that additional diagnostic tests may still need to be done.
5. I agree to provide an additional sample if the initial sample is not adequate.

PATIENT CONFIDENTIALITY AND GENETIC COUNSELING

It is recommended that I receive genetic counseling before and after having this genetic test. I can find a genetic counselor in my area at www.nsgc.org. Further testing or additional consultations with a healthcare provider may be necessary. To maintain confidentiality, test results will only be released to the referring healthcare provider, the ordering laboratory, to me, to other healthcare providers involved in my care, diagnosis and treatment, or to others with my consent or as permitted or required by law. Federal laws prohibit unauthorized disclosure of this information. More information can be found at: www.genome.gov/10002077

INTERNATIONAL SAMPLES

If I reside outside the United States, I attest that by providing a sample for testing, I am not knowingly violating any export ban or other legal restriction in the country of my residence.

SAMPLE RETENTION

After testing is complete, my sample may be de-identified and be used for test development and improvement, internal validation, quality assurance, and training purposes. Preventive Genomics will not return DNA samples to you or to referring healthcare providers, unless specific prior arrangements have been made.

I understand that samples from residents of New York State will not be included in the de-identified research studies described in this authorization and Preventive Genomics will not retain them for more than 60 days after test completion, unless specifically authorized by my selection. The authorization is optional, and testing will be unaffected if I do not check the box for the New York authorization language. Preventive Genomics will not perform any tests on the biological sample other than those specifically authorized.

DATABASE PARTICIPATION

De-identified health history and genetic information can help healthcare providers and scientists understand how genes affect human health. Sharing this deidentified information helps healthcare providers to provide better care for their patients and researchers to make new discoveries. Preventive Genomics shares this type of information with healthcare providers, scientists, and healthcare databases. Preventive Genomics will not share any personally identifying information and will replace the identifying information with a unique code not derived from any personally identifying information. Even with a unique code, there is a risk that I could be identified based on the genetic and health information that is shared. Preventive Genomics believes that this is unlikely, though the risk is greater if I have already shared my genetic or health information with public resources, such as genealogy websites.

EXOME/GENOME SEQUENCING SECONDARY FINDINGS

- Applicable only for full exome sequencing and genome sequencing tests
- Does not pertain to Xpanded® or Slice tests

As many different genes and conditions are analyzed in an exome or genome sequencing test, these tests may reveal some findings not directly related to the reason for ordering the test. Such findings are called "incidental" or "secondary" and can provide information that was not anticipated.

Secondary findings are variants, identified by an exome or genome sequencing test, in genes that are unrelated to the individual's reported clinical features.

The American College of Medical Genetics and Genomics (ACMG) has recommended that secondary findings identified in a specific subset of medically actionable genes associated with various inherited disorders be reported for all probands undergoing exome or genome sequencing. Please refer to the latest version of the ACMG recommendations for reporting of secondary findings in clinical exome and genome sequencing for complete details of the genes and associated genetic disorders. Reportable secondary findings will be confirmed by an alternate test method when needed.

WHAT WILL BE REPORTED FOR THE PATIENT?

All pathogenic and likely pathogenic variants associated with specific genotypes identified in the genes (for which a minimum of 10X coverage was achieved by exome sequencing or a minimum of 15X coverage was achieved by genome sequencing), as recommended by the ACMG.

WHAT WILL BE REPORTED FOR RELATIVES?

The presence or absence of any secondary finding(s) reported for the proband will be provided for all relatives analyzed by an exome or genome sequencing test.

LIMITATIONS

Pathogenic and/or likely pathogenic variants may be present in a portion of the gene not covered by this test and therefore are not reported. The absence of reportable secondary findings for any particular gene does not mean there are no pathogenic and/or likely pathogenic variants in that gene. Pathogenic variants and/or likely pathogenic variants that may be present in a relative, but are not present in the proband, will not be identified nor reported. Only changes at the sequence level will be reported in the secondary findings report. Larger deletions/duplications, abnormal methylation, triplet repeat or other expansion variants, or other variants not routinely identified by clinical exome and genome sequencing will not be reported.

FINANCIAL AGREEMENT AND GUARANTEE

For insurance billing, I understand and authorize Preventive Genomics to bill my health insurance plan on my behalf, to release any information required for billing, and to be my designated representative for purposes of appealing any denial of benefits. I irrevocably assign to and direct that payment be made directly to Preventive Genomics.

I understand that my out-of-pocket costs may be different than the estimated amount indicated to me by Preventive Genomics as part of a benefit investigation. I agree to be financially responsible for any and all amounts as indicated on the explanation of benefits issued by my health insurance plan. If my insurance provider sends a payment directly to me for services performed by Preventive Genomics on my behalf, I agree to endorse the insurance check and forward it to Preventive Genomics within 30 days of receipt as payment towards Preventive Genomics claim for services rendered.

If I do not have health insurance, I agree to pay for the full cost of the genetic testing that was ordered by my healthcare provider and billed to me by Preventive Genomics. I further understand and agree that, if I fail to make payment for genetic testing, in accordance with the payment policies of Preventive Genomics, my account may be turned over to an external collection agency for non-payment. I agree to pay any associated collection costs, including attorney fees. By my signature on the Preventive Genomics Test Requisition Form or at the bottom of this form, I accept full and complete financial responsibility for all genetic testing ordered by my healthcare provider.