



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

PRIMARY IMMUNODEFICIENCY 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 |
| 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

- ☐ Buccal Swab
- ☐ Extracted DNA
- Sample Draw Date (mm/dd/yyyy)
...../...../.....

Shipping Instructions

- 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

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

Has patient received a bone marrow transplant?

☐ Yes ☐ No

If yes, date of bone marrow transplant _____

Percent engraftment _____

General

- ☐ Acute liver failure
- ☐ Fever(s)
- ☐ Failure to thrive
- ☐ (Hepato)splenomegaly
- ☐ Lethargy
- ☐ Respiratory insufficiency/failure
- ☐ Sudden unexplained coma/death
- ☐ Other; specify _____

Head and Neck

- ☐ Abnormal CT/MRI of brain; specify _____
- ☐ Dysmorphic facies
- ☐ Enlarged lymph nodes
- ☐ Microcephaly
- ☐ Oral leukoplakia
- ☐ Small lymph nodes and/or tonsils
- ☐ Thymic hypoplasia
- ☐ Other; specify _____

Skin

- ☐ Alopecia
- ☐ Eczema
- ☐ Hypopigmentation/ hyperpigmentation
- ☐ Rash/dermatitis
- ☐ Telangiectasia of eyes or skin
- ☐ Dysplastic nails
- ☐ Other skin lesions; specify _____

Hematologic History

- ☐ Bone marrow failure
- ☐ Cytopenias (2 of 3 cell lineages)
- ☐ Leukopenia/neutropenia
- ☐ Red cell anemia
- ☐ Thrombocytopenia/small platelets
- ☐ Other; specify _____

Oncologic History

- ☐ Lymphoma; specify type _____
- ☐ Myelodysplasia/AML
- ☐ Other leukemia; specify type _____
- ☐ Recurrent primary tumors; specify types _____
- ☐ Solid tumor; specify type _____
- ☐ Other; specify _____

Infectious Disease History

- ☐ Recurrent, unusual or difficult to treat infections
___viral ___bacterial ___fungal
- ☐ Recurrent pneumonia, ear infections or sinusitis
- ☐ Recurrent deep abscesses of the organs or skin
- ☐ VMultiple courses of antibiotics or IV antibiotics necessary
to clear infections
- ☐ Other; specify _____
- Laboratory findings
 - ☐ Anemia
 - ☐ Decreased telomere length
 - ☐ Neutropenia/leukopenia
 - ☐ Thrombocytopenia
 - ☐ Abnormal ALPS panel
 - ☐ Abnormal mitogen stimulation
 - ☐ Abnormal lymphocyte subsets
 - ☐ Abnormal TREC assay
 - ☐ Abnormal B cell function; specify _____
 - ☐ Abnormal T cell function; specify _____
 - ☐ Low or absent NK function
 - ☐ Complementation group correction (specify) _____
 - ☐ Increased chromosome breakage
 - ☐ ↑ ferritin
 - ☐ ↑ soluble IL2Ra
 - ☐ ↑ triglycerides and/or ↓fibrinogens
 - ☐ Abnormal protein assay by flow cytometry; specify _____
 - ☐ Other; specify _____

Congenital abnormalities/malformations/dysmorphic features (Please specify)

Other Symptoms (Please specify)

FAMILY HISTORY

☐ No Known Family History ☐ Pedigree Attached ☐ Adopted

| Relationship | Maternal | Paternal | Relavant 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 ☒ COMPREHENSIVE PANEL

REQUIRED

- | | | | | | | | |
|--------------------------------|-------------------------------|---------------------------------|---------------------------------|--------------------------------|---------------------------------|---------------------------------|------------------------------------|
| <input type="checkbox"/> ATM | <input type="checkbox"/> CFTR | <input type="checkbox"/> F9 | <input type="checkbox"/> IFNGR2 | <input type="checkbox"/> MSH2 | <input type="checkbox"/> PALB2 | <input type="checkbox"/> RAG2 | <input type="checkbox"/> STK4 |
| <input type="checkbox"/> BLM | <input type="checkbox"/> CYBA | <input type="checkbox"/> FANCC | <input type="checkbox"/> ITGB2 | <input type="checkbox"/> MSH6 | <input type="checkbox"/> PIK3CD | <input type="checkbox"/> RFXANK | <input type="checkbox"/> TERT |
| <input type="checkbox"/> BRCA1 | <input type="checkbox"/> CYBB | <input type="checkbox"/> FGB | <input type="checkbox"/> JAK2 | <input type="checkbox"/> MYD88 | <input type="checkbox"/> PLCG2 | <input type="checkbox"/> RUNX1 | <input type="checkbox"/> TNFRSF13B |
| <input type="checkbox"/> BRCA2 | <input type="checkbox"/> F13B | <input type="checkbox"/> G6PC | <input type="checkbox"/> JAGN1 | <input type="checkbox"/> NCF1 | <input type="checkbox"/> PMS2 | <input type="checkbox"/> SPINK5 | <input type="checkbox"/> VPS13B |
| <input type="checkbox"/> BTK | <input type="checkbox"/> F5 | <input type="checkbox"/> G6PD | <input type="checkbox"/> MEFV | <input type="checkbox"/> NFKB2 | <input type="checkbox"/> PTPRC | <input type="checkbox"/> STAT1 | |
| <input type="checkbox"/> CDX1 | <input type="checkbox"/> F7 | <input type="checkbox"/> IFNGR1 | <input type="checkbox"/> MPL | <input type="checkbox"/> NRAS | <input type="checkbox"/> RAG1 | <input type="checkbox"/> STAT3 | |

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.

| | | | |
|----------------------------------|---|----------------------------------|--|
| <input type="checkbox"/> D17.1 | Benign lipomatous neoplasm of skin and subcutaneous tissue of trunk | <input type="checkbox"/> I63.30 | Cerebral infarction due to thrombosis of unspecified cerebral artery |
| <input type="checkbox"/> D25.9 | Leiomyoma of uterus, unspecified | <input type="checkbox"/> J30.1 | Allergic rhinitis due to pollen |
| <input type="checkbox"/> D51.0 | Vitamin B12 deficiency anemia due to intrinsic factor deficiency | <input type="checkbox"/> J30.2 | Other seasonal allergic rhinitis |
| <input type="checkbox"/> D51.1 | Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria | <input type="checkbox"/> J32.2 | Chronic ethmoidal sinusitis |
| <input type="checkbox"/> D59.9 | Acquired hemolytic anemia, unspecified | <input type="checkbox"/> J32.9 | Chronic sinusitis, unspecified |
| <input type="checkbox"/> D63.1 | Anemia in chronic kidney disease | <input type="checkbox"/> J41.8 | Mixed simple and mucopurulent chronic bronchitis |
| <input type="checkbox"/> D72.10 | Eosinophilia, unspecified | <input type="checkbox"/> J42 | Unspecified chronic bronchitis |
| <input type="checkbox"/> D77 | Other disorders of blood and blood-forming organs in diseases classified elsewhere | <input type="checkbox"/> J43.2 | Centrilobular emphysema |
| <input type="checkbox"/> D80.1 | Nonfamilial hypogammaglobulinemia | <input type="checkbox"/> J44.1 | Chronic obstructive pulmonary disease with (acute) exacerbation |
| <input type="checkbox"/> D83.0 | Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function | <input type="checkbox"/> J44.9 | Chronic obstructive pulmonary disease, unspecified |
| <input type="checkbox"/> D84.9 | Hypothyroidism, unspecified | <input type="checkbox"/> J45.21 | Mild intermittent asthma with (acute) exacerbation |
| <input type="checkbox"/> E03.9 | Hypothyroidism, unspecified | <input type="checkbox"/> J45.909 | Unspecified asthma, uncomplicated |
| <input type="checkbox"/> E05.00 | Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm | <input type="checkbox"/> J96.10 | Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia |
| <input type="checkbox"/> E06.3 | Autoimmune thyroiditis | <input type="checkbox"/> K25.9 | Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation |
| <input type="checkbox"/> E06.9 | Thyroiditis, unspecified | <input type="checkbox"/> K30 | Functional dyspepsia |
| <input type="checkbox"/> E10.8 | Type 1 diabetes mellitus with unspecified complications | <input type="checkbox"/> K57.90 | Diverticulosis of intestine, part unspecified, without perforation or abscess without bleeding |
| <input type="checkbox"/> E11.22 | Type 2 diabetes mellitus with diabetic chronic kidney disease | <input type="checkbox"/> K58.8 | Other irritable bowel syndrome |
| <input type="checkbox"/> E11.42 | Type 2 diabetes mellitus with diabetic polyneuropathy | <input type="checkbox"/> K86.81 | Exocrine pancreatic insufficiency |
| <input type="checkbox"/> E11.65 | Type 2 diabetes mellitus with hyperglycemia | <input type="checkbox"/> K90.0 | Celiac disease |
| <input type="checkbox"/> E11.9 | Type 2 diabetes mellitus without complications | <input type="checkbox"/> K92.9 | Disease of digestive system, unspecified |
| <input type="checkbox"/> E66.01 | Morbid (severe) obesity due to excess calories | <input type="checkbox"/> L20.9 | Atopic dermatitis, unspecified |
| <input type="checkbox"/> E78.00 | Pure hypercholesterolemia, unspecified | <input type="checkbox"/> L40.50 | Arthropathic psoriasis, unspecified |
| <input type="checkbox"/> E78.1 | Pure hyperglyceridemia | <input type="checkbox"/> L40.52 | Psoriatic arthritis mutilans |
| <input type="checkbox"/> E78.2 | Mixed hyperlipidemia | <input type="checkbox"/> L40.8 | Other psoriasis |
| <input type="checkbox"/> E78.5 | Hyperlipidemia, unspecified | <input type="checkbox"/> M06.9 | Rheumatoid arthritis, unspecified |
| <input type="checkbox"/> E79.0 | Hyperuricemia without signs of inflammatory arthritis and tophaceous disease | <input type="checkbox"/> M13.80 | Other specified arthritis, unspecified site |
| <input type="checkbox"/> E83.30 | Disorder of phosphorus metabolism, unspecified | <input type="checkbox"/> M17.0 | Bilateral primary osteoarthritis of knee |
| <input type="checkbox"/> E87.5 | Hyperkalemia | <input type="checkbox"/> M17.9 | Osteoarthritis of knee, unspecified |
| <input type="checkbox"/> E89.0 | Postprocedural hypothyroidism | <input type="checkbox"/> M19.049 | Primary osteoarthritis, unspecified hand |
| <input type="checkbox"/> F01.50 | Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety | <input type="checkbox"/> M19.90 | Unspecified osteoarthritis, unspecified site |
| <input type="checkbox"/> F41.1 | Generalized anxiety disorder | <input type="checkbox"/> M32.9 | Systemic lupus erythematosus, unspecified |
| <input type="checkbox"/> F41.9 | Anxiety disorder, unspecified | <input type="checkbox"/> M34.89 | Other systemic sclerosis |
| <input type="checkbox"/> F45.21 | Hypochondriasis | <input type="checkbox"/> M35.00 | Sjogren syndrome, unspecified |
| <input type="checkbox"/> F51.04 | Psychophysiologic insomnia | <input type="checkbox"/> M81.0 | Age-related osteoporosis without current pathological fracture |
| <input type="checkbox"/> G35 | Multiple sclerosis | <input type="checkbox"/> N18.2 | Chronic kidney disease, stage 2 (mild) |
| <input type="checkbox"/> G47.30 | Sleep apnea, unspecified | <input type="checkbox"/> N40.0 | Benign prostatic hyperplasia without lower urinary tract symptoms |
| <input type="checkbox"/> H35.30 | Unspecified macular degeneration | <input type="checkbox"/> R41.3 | Other amnesia |
| <input type="checkbox"/> I10 | Essential (primary) hypertension | <input type="checkbox"/> R59.0 | Localized enlarged lymph nodes |
| <input type="checkbox"/> I12.9 | Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease | <input type="checkbox"/> Z85.828 | Personal history of other malignant neoplasm of skin |
| <input type="checkbox"/> B20 | Human immunodeficiency virus [HIV] disease. | <input type="checkbox"/> Z86.2 | Personal history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism |
| <input type="checkbox"/> B37.9 | Candidiasis, unspecified A fungal infection caused by Candida species, not specified by site. | <input type="checkbox"/> Z86.39 | Personal history of other endocrine, nutritional and metabolic disease |
| <input type="checkbox"/> C81.43 | Other Hodgkin lymphoma, mixed cellularity, spleen. | <input type="checkbox"/> Z87.2 | Personal history of diseases of the skin and subcutaneous tissue |
| <input type="checkbox"/> C85.90 | Non-Hodgkin lymphoma, unspecified, unspecified site A type of cancer that starts in cells called lymphocytes, which are part of the body's immune system. The specific type of lymphocyte and the site are not specified. | <input type="checkbox"/> D82.8 | Other specified immunodeficiencies Various other specified immunodeficiencies. |
| <input type="checkbox"/> C88.8 | Other malignant immunoproliferative diseases This includes other specified malignant disorders where the immune system produces excessive amounts of abnormal cells. | <input type="checkbox"/> D82.9 | Immunodeficiency, unspecified An unspecified condition affecting the immune system. |
| <input type="checkbox"/> C90.00 | Multiple myeloma not having achieved remission A cancer of plasma cells that has not yet responded to treatment. | <input type="checkbox"/> D83.1 | Common variable immunodeficiency with predominant immunoregulatory A disorder with T-cell disorders dysfunction and variable antibody deficiencies. |
| <input type="checkbox"/> C94.41 | Acute erythroid leukemia A rare and aggressive type of leukemia that primarily affects red blood cell precursors. | <input type="checkbox"/> D83.2 | Common variable immunodeficiency with autoantibodies to B-cell dysfunction and variable antibody deficiencies. |
| <input type="checkbox"/> C94.6 | Myelodysplastic disease, unspecified A group of disorders caused by poorly formed or dysfunctional blood cells, not otherwise specified. | <input type="checkbox"/> D83.8 | Other common variable immunodeficiencies Various other types of common variable immunodeficiencies. |
| <input type="checkbox"/> D46.9 | Myelodysplastic syndrome, unspecified. | <input type="checkbox"/> D60.0 | Constitutional aplastic anemia. |
| <input type="checkbox"/> D47.2 | Monoclonal gammopathy A condition where an abnormal protein (monoclonal protein or M protein) is found in the blood. | <input type="checkbox"/> D60.9 | Acquired pure red cell aplasia, unspecified A rare disorder where the bone marrow stops producing red blood cells. |
| <input type="checkbox"/> D52.9 | Dietary vitamin B12 deficiency anemia, unspecified. | <input type="checkbox"/> D61.3 | Idiopathic aplastic anemia A condition where the body stops producing enough new blood cells, without a known cause. |
| <input type="checkbox"/> D60.0 | Constitutional aplastic anemia. | <input type="checkbox"/> D61.818 | Other pancytopenia A condition characterized by a deficiency of all types of blood cells (red, white, and platelets). |
| <input type="checkbox"/> D60.9 | Acquired pure red cell aplasia, unspecified A rare disorder where the bone marrow stops producing red blood cells. | <input type="checkbox"/> D64.0 | Hereditary sideroblastic anemia. |
| <input type="checkbox"/> D61.3 | Idiopathic aplastic anemia A condition where the body stops producing enough new blood cells, without a known cause. | <input type="checkbox"/> D64.81 | Anemia due to antineoplastic chemotherapy Anemia caused by cancer treatment drugs. |
| <input type="checkbox"/> D61.818 | Other pancytopenia A condition characterized by a deficiency of all types of blood cells (red, white, and platelets). | <input type="checkbox"/> D69.3 | Immune thrombocytopenic purpura A disorder that can lead to easy or excessive bruising and bleeding, resulting from unusually low levels of platelets. |

Continued

| | |
|---|---|
| <div><div><input type="checkbox"/> D69.9 Hemorrhagic condition, unspecified.</div><div><input type="checkbox"/> D70.8 Other neutropenia A condition involving an abnormally low count of neutrophils, a type of white blood cell.</div><div><input type="checkbox"/> D71 Functional disorders of polymorphonuclear neutrophils.</div><div><input type="checkbox"/> D72.810 Lymphocytopenia A condition involving a lower-than-normal count of lymphocytes, a type of white blood cell.</div><div><input type="checkbox"/> D72.818 Other decreased white blood cell count Conditions where white blood cell count is abnormally low.</div><div><input type="checkbox"/> D72.819 Decreased white blood cell count, unspecified A condition with an unspecified low white blood cell count.</div><div><input type="checkbox"/> D72.820 Lymphocytopenia.</div><div><input type="checkbox"/> D80.0 Hereditary hypogammaglobulinemia A genetic disorder where the body produces very low levels of immunoglobulin G (IgG).</div><div><input type="checkbox"/> D80.1 Nonfamilial hypogammaglobulinemia A non-genetic disorder where the body produces low levels of immunoglobulins.</div><div><input type="checkbox"/> D80.4 Selective deficiency of immunoglobulin M [IgM] A condition where the body produces low levels of IgM.</div><div><input type="checkbox"/> D80.6 Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia An immune deficiency where antibody levels are near normal or elevated.</div><div><input type="checkbox"/> D80.8 Other immunodeficiencies with predominantly antibody defects Various other conditions primarily affecting antibody production.</div><div><input type="checkbox"/> D80.9 Immunodeficiency with predominantly antibody defects, unspecified Unspecified conditions affecting antibody production.</div><div><input type="checkbox"/> D81.89 Other combined immunodeficiencies Various combined immuno deficiencies not otherwise specified.</div><div><input type="checkbox"/> D81.9 Combined immunodeficiency, unspecified An unspecified disorder affecting multiple parts of the immune system.</div><div><input type="checkbox"/> D82.4 Hyperimmunoglobulin E [IgE] syndrome A disorder characterized by high levels of IgE and recurrent infections.</div><div><input type="checkbox"/> D83.9 Common variable immunodeficiency, unspecified Unspecified common variable immunodeficiency.</div><div><input type="checkbox"/> D84.0 Lymphocyte function antigen-1 (LFA-1) defect.</div><div><input type="checkbox"/> D84.821 Immunodeficiency due to drugs and external causes Immune deficiency resulting from medications or external factors.</div><div><input type="checkbox"/> D84.89 Other immunodeficiencies Various other specified immunodeficiencies.</div></div> | <div><div><input type="checkbox"/> D89.89 Other specified disorders involving the immune mechanism, not elsewhere classified Various other immune disorders not classified elsewhere.</div><div><input type="checkbox"/> D89.9 Disorder involving the immune mechanism, unspecified An unspecified immune disorder.</div><div><input type="checkbox"/> E03.8 Other specified hypothyroidism.</div><div><input type="checkbox"/> E05.0 Thyrotoxicosis with diffuse goiter.</div><div><input type="checkbox"/> E05.90 Thyrotoxicosis, unspecified without thyrotoxic crisis or storm.</div><div><input type="checkbox"/> E06.0 Subacute thyroiditis.</div><div><input type="checkbox"/> E06.1 Subacute thyroiditis</div><div><input type="checkbox"/> E11.618 Type 2 diabetes mellitus with other diabetic arthropathy.</div><div><input type="checkbox"/> E29.0 Testicular hypofunction.</div><div><input type="checkbox"/> E43 Unspecified severe protein-calorie malnutrition A severe deficiency of protein and calories, unspecified.</div><div><input type="checkbox"/> E46 Unspecified protein-calorie malnutrition.</div><div><input type="checkbox"/> E88.81 Metabolic syndrome.</div><div><input type="checkbox"/> L08.1 Erythrasma.</div><div><input type="checkbox"/> L08.9 Local infection of the skin and subcutaneous tissue, unspecified.</div><div><input type="checkbox"/> M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement Rheumatoid arthritis affecting multiple sites.</div><div><input type="checkbox"/> M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified Rheumatoid arthritis with rheumatoid factor, unspecified.</div><div><input type="checkbox"/> M32.10 Drug-induced systemic lupus erythematosus Lupus caused by drug reactions.</div><div><input type="checkbox"/> M45.0 Ankylosing spondylitis of multiple sites in spine A type of arthritis affecting multiple sites in the spine.</div><div><input type="checkbox"/> M45.6 Ankylosing spondylitis of lumbar spine Arthritis affecting the lumbar spine.</div><div><input type="checkbox"/> M45.9 Ankylosing spondylitis of unspecified sites in spine Arthritis affecting unspecified sites in the spine.</div><div><input type="checkbox"/> R53.0 Neoplastic (malignant) related fatigue.</div><div><input type="checkbox"/> T86.40 Unspecified complications of bone marrow transplant Complications arising from bone marrow transplants, unspecified.</div><div><input type="checkbox"/> Z83.2 Family history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism Family history of blood and immune system disorders.</div><div><input type="checkbox"/> Z85.71 Personal history of Hodgkin lymphoma History of having Hodgkin lymphoma.</div><div><input type="checkbox"/> Z85.72 Personal history of non-Hodgkin lymphoma History of having non-Hodgkin lymphoma.</div></div> |
|---|---|

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**

RISKS AND LIMITATIONS OF GENETIC TESTING

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.