MMGL MOLECULAR GENETICS REQUISITION

MLabs
Expertise Delivered Personally

Michigan Medicine – University of Michigan
Department of Pathology – MLabs
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Client
REFM

Ward
REFM

Patient Reg or MRN:

Patient Name: Last First MI

Birthdate: Gender: ○M ○F

Ordering Doctor: Last First NPI#

Patient Address City State ZIP Home Phone #

Policy Holders Name | Primary Insurance (Card Name) | Primary Policy/Contract # | Primary Group # | Policy Holders DOB

Policy Holders Name | Secondary Insurance (Card Name) | Secondary Policy/Contract # | Secondary Group # | Policy Holders DOB

Bill To: ☐ Client/Referring Institution ☐ Patient/Insurance

☐ Medicare = ☐ In Patient on DOS ☐ Out Patient on DOS ☐ Non Patient on DOS

If patient or insurance information is not included or attached to this form, your facility will be billed. For Medicare patients classified as a hospital inpatient or outpatient on the date of service, charges must be billed to the referring client.

Prior Authorization: Most insurance carriers require prior authorization for payment. To obtain Blue Care Network (BCN) prior authorization call Joint Venture Hospital Laboratories (JVHL) at 800-445-4979. For all other carriers contact the plan directly.

☐ Prior authorization obtained Authorization number: _____

Informed Consent: A consent form is required by Michigan law for presymptomatic or predictive genetic tests. It is the responsibility of the physician (or designee) to obtain this consent. If desired, a UMHS Request and Consent for Genetic Testing form can be obtained by contacting MLabs at 800-862-7284 or online at http://mlabs.umich.edu/files/pdfs/PCI-MMGL_InformedConsent.pdf.

☐ Informed consent obtained (please attach a copy).

ICD-10 CODES

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only tests that are medically necessary for the diagnosis and treatment of the patient.

REFERRING PHYSICIAN TO BE CONTACTED WITH RESULTS AND/OR QUESTIONS

Referring Physician Referring Institution Phone Fax

Address City State ZIP Country

This request to order tests from MLabs certifies to MLabs that (1) the ordering physician has obtained written informed consent from the patient as required by applicable state or federal laws for each test ordered and (2) the ordering physician has authorization from the patient permitting MLabs to report results for each test ordered to the ordering physician.

PATIENT HISTORY/DIAGNOSIS

Diagnosis: _____ Collection Date: _____ Time: _____ (○am ○pm) Footnote: Case/Accn # _____

All tests include pathologist interpretation at a separate additional charge.

MICROARRAY
☐ Chromosomal Microarray Analysis (SNPM1)

AUTISM / INTELLECTUAL DISABILITY
☐ Autism / ID Panel reflex to all Tiers (AUS)
☐ Autism / ID Panel Tier 1 (AUS1) includes SNPM1, FRXFA, PWSMP
☐ Autism / ID Panel Tier 2 (AUS2) includes MECS, PTENS, MECD, PTED
☐ Autism / ID Panel Tier 3 (AUS3) includes UBE3A, MBD5S, NLGN3, NLGN4, SHNK2, SHNK3, SLC9A, TCF4S, CDKL5
☐ CDKL5 Gene Sequencing (CDKL5)
☐ GDI1 Gene Sequencing (GDI1)
☐ Fragile X Syndrome Mutation (FRXFA)
☐ MBD5 Gene Sequencing (MBD5S)

MECP2 (Rett Syndrome)
☐ Gene Sequencing (MECS)
☐ Deletion/Duplication (MECD)
☐ Targeted Sequencing Familial (MECF)

☐ MEF2C Gene Sequencing (MEFS)
☐ NLGN3 Gene Sequencing (NLGN3)
☐ NLGN4X Gene Sequencing (NLGN4)
☐ Prader-Willi / Angelman Syndrome by PCR (PWSMP)

PTEN Hamartoma Tumor Syndrome (PHTS)
☐ Gene Sequencing (PTENS)
☐ Deletion/Duplication (PTED)
☐ Targeted Sequencing Familial (PTENF)
☐ PTEN Promoter Sequencing

☐ SHANK2 Gene Sequencing (SHNK2)
☐ SHANK3 Gene Sequencing (SHNK3)
☐ SLC9A6 Gene Sequencing (SLC9A)
☐ TCF4 (Pitt-Hopkins Syndrome) Gene Sequencing (TCF4S)
☐ UBE3A Gene Sequencing (UBE3A)

HEARING LOSS
☐ GJB2 (Connexin 26) Mutation Analysis (CX26S) includes reflex to GJB6 (Connexin 30) Deletion
☐ GJB2 (Connexin 26) Targeted Sequencing Familial (CX26F)
☐ WFS1 (Wolfram Syndrome) Gene Sequencing (WFS1)
☐ SLC17A8 632C>T (A21V) Mutation Detection (SLC17)

NOONAN SYNDROME
☐ Noonan Syndrome reflex to all Tiers (NSSTS)
☐ Noonan Syndrome Tier 1 (NSST1) includes PTPN11 exons 3, 8, 13, SOS1 exons 3, 6, 10, 16, RAF1 exons 7, 14, 17
☐ Noonan Syndrome Tier 2 (NSST2) includes PTPN11 exons 1, 2, 4-7, 9-12, 14, 15
☐ Noonan Syndrome Tier 3 (NSST3) includes SOS1 exons 1, 2, 4, 5, 7-9, 11-15, 17-23, KRAS2 exons 2-6
☐ PTPN11 Gene Sequencing in Inherited Disorders (PTPNS)
☐ SOS1 Gene Sequencing in Inherited Disorders (SOS1S)
☐ KRAS Gene Sequencing in Inherited Disorders (RASKS)

OTHER
☐ ATP7B Gene Sequencing (ATP7B)
☐ BTD Gene Sequencing (BTDS)
☐ CHD7 Gene Sequencing (CHD7S)
☐ DiGeorge Panel (DIGP1) includes reflex to Chromosomal Microarray
☐ GAA Gene Sequencing (GAAS)

MSH2
☐ Gene Sequencing (MSH2S)
☐ MSH2 Targeted Sequencing Familial (MSH2F)

☐ NF1 Gene Sequencing (NF1S)
☐ NOGGIN Gene Sequencing (NOGS)
☐ Ornithine Transcarbamylase Deficiency (OTC) Gene Sequencing (OTCS)
☐ PAI1 (SERPINE1) Mutation Detection (PAI1M)
☐ SERPINE1 Gene Sequencing (SERPS)
☐ SETBP1 Mutation Detection (SETM)
☐ SLC7A7 Gene Sequencing (SLC7A)
☐ SMN1&2 Deletion / Copy Number Analysis (SMN1D)

TP53
☐ Gene Sequencing (TP53S)
☐ Deletion/Duplication Analysis (TP53D)

☐ Other: _____

Specimen Type for all assays: Peripheral Blood, 5-10 mL Lavender/EDTA tube For technical questions, call lab (734) 615-2429

Copy Distribution: White – MLabs Mol Dx Yellow – MLabs SP Pink – Client

Revised: 5-16-2017 I-REFM