

PATIENT INFORMATION

 Last Name _____
 First Name _____ MI _____
 Parent name (if pt is a minor)/Spouse _____
 Pt. ID/Med Rec# _____
 DOB ____/____/____ (MM/DD/YYYY)
 Gender Male Female Unknown Ambiguous
 Ethnicity of pt. (check all that apply)
 African-American Asian
 Caucasian/NW European E. Indian Hispanic Jewish-Ashkenazi
 Jewish-Sephardic Mediterranean Native American
 Native Hawaiian/Other Pacific Islander Other _____
 Address _____

 City _____ State _____ Zip _____
 Preferred Phone (____) _____ - _____
 Secondary Phone (____) _____ - _____

ENTITY ORDERING TEST (Fax # Required to Receive Report)
 Physician
 Name _____
 NPI _____
 Phone (____) _____ - _____ Fax (____) _____ - _____
 Email _____
 Laboratory/Institution
 Name _____
 Address _____
 Address 2: _____
 City _____ State _____ Zip _____
 Phone (____) _____ - _____ Fax (____) _____ - _____
 Email _____

DUPLICATE REPORTS TO (Fax # Required to Receive Report)
 Genetic Counselor
 Name _____
 Phone (____) _____ - _____ Fax (____) _____ - _____
 Email _____
 Other
 Name _____
 Phone (____) _____ - _____ Fax (____) _____ - _____
 Email _____

BILLING INFORMATION *Required*

 ICD9 Codes: _____
 Please complete billing information on page 2 of this form.

INFORMATION FOR HEALTH CARE PROVIDERS AND PATIENTS

Emory Genetics Laboratory retains patient samples indefinitely for validation, educational purposes and/or research. For molecular cytogenetic and some molecular genetic tests, submitted clinical information and test results are also included in HIPAA-compliant, de-identified public databases as part of the National Institute of Health's effort to improve diagnostic testing and our understanding of the relationships between genetic changes and clinical symptoms (for information about the molecular cytogenetic database, visit the consortium website at <https://www.iscaconsortium.org/> and for information about the molecular genetic database refer to the individual test descriptions). Confidentiality of each sample is maintained. Patients may request to withdraw consent for the storage of their sample and/or use of the data by: 1) calling the laboratory at 1-855-831-7447 and asking to speak with a laboratory genetic counselor or 2) visiting our website at <http://www.geneticslab.emory.edu/opt-out>.

Refusal for inclusion in these efforts may be indicated by checking this box. (If the box is not checked the data will be anonymized and used.)

SPECIMEN INFORMATION

 Date Collected ____/____/____ (MM/DD/YYYY)
 Time ____:____ AM PM

SAMPLE TYPE
 Whole Blood Saliva DNA Muscle Biopsy Skin Biopsy DBS
 Serum Urine Plasma, Hep Plasma, EDTA Plasma, Other
 Leukocyte Pellet CSF Cult Fibroblast PUBS Other _____

PRENATAL SAMPLE TYPE
 Amniotic Fluid Cultured Amniotic Fluid POC
 Chorionic Villus Cultured Chorionic Villus DNA From _____

CLINICAL INFORMATION *REQUIRED*
Clinical findings/family history/test results (attach copies if appropriate)
 Indication Diagnostic Carrier

Is patient/spouse/family member pregnant?
 No Yes **Check if relevant** Egg donor Sperm donor
 LMP _____ EDD _____

Genotypes

Proband _____	<input type="checkbox"/> Formula <input type="checkbox"/> MCT Oil
Mother _____	<input type="checkbox"/> Breast Milk <input type="checkbox"/> Hyperal
Father _____	<input type="checkbox"/> Special _____

Medications
 Anticonvulsants Antidepressants Antibiotics HAF/TPN
 Carnitine Oral Contraceptives Other _____

Has Patient had any of the following?
 Transfusion Bone Marrow Transplant

FOR LAB USE ONLY

 Rec/d ____/____/____ Unboxed By _____
 Sender _____

TEMP	SPECIMEN	COLOR	# TUBES	COMP.	INCOMP.
R C F				PT. DATA	[] []
R C F				TEST DATA	[] []
R C F				PHYSICIAN DATA	[] []
R C F				BILLING DATA	[] []

BILLING
 Hold Billing _____
 Facility Bill Acct # _____ QC _____
 Insurance Bill Reflex _____
 Self-Pay Specimen _____
 Accessioned by: _____ Labeled by: _____ Pickup: _____

Patient Name: Last _____ First _____ MI _____

 Submit this completed payment options form with the specimen. Testing is not initiated until billing information is received. Billing policy information is available at <http://geneticslab.emory.edu/billing>.

PAYMENT OPTIONS (please select one of the following options)
1 - INSTITUTION

For new clients, to establish an institutional account, you must complete an Institutional Account Request Form **prior** to submitting an order. The form can be downloaded at <http://geneticslab.emory.edu/billing>. For any questions or to confirm whether you have an account or what your account number is, please contact our billing office at 404-778-8580 or by email at eglbilling@emory.edu.

Institution _____ Account # _____

The following information is not required if account number is provided above:

Contact Name _____ Email _____

Billing Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

EGL Billing Label
Please call to request labels
2 - SELF PAY
 Cashier Check Visa MasterCard Discover

Amount \$ _____ (include discount if applicable)

Credit Card # _____ Expiration Date ____/____/____

Cardholder Billing Address _____

City _____ State _____ Zip _____

Cardholder Phone _____

Required for credit card payments

Cardholder Printed Name as it Appears on Card _____

Cardholder Signature _____

3 - INSURANCE (Also includes Wellcare, Amerigroup, Peachstate for GA Residents and Medicare).

EGL does not accept Georgia Medicaid or any out of state Medicaid.

 A **legible** front and back copy of insurance card and insurance authorization must be included. A completed Advance Beneficiary Notice of coverage (ABN) is required for Medicare patients.

ICD9 Diagnosis Code(s) *Required _____

PRIMARY Policyholder Name _____ DOB ____/____/____

 Relationship to the Patient Self Spouse Dependent Other _____ Gender Male Female

Insurance Co. Name _____ Policy No. _____ Group No. _____

Address _____

City _____ State _____ Zip _____

Phone _____ Authorization Number (Copy of authorization letter also required) _____

SECONDARY Policyholder Name _____ DOB ____/____/____

 Relationship to the Patient Self Spouse Dependent Other _____ Gender Male Female

Insurance Co. Name _____ Policy No. _____ Group No. _____

Address _____

City _____ State _____ Zip _____

Phone _____ Authorization Number (Copy of authorization letter also required) _____

Authorization to assign benefits, accept financial responsibility, and disclose health records

If I am entitled to benefits under the Medicare program, or any insurance policy or other health benefit plan, in consideration for services provided to me by EGL, I assign, transfer and convey the benefits payable under such program, policy or plan for such services to EGL. I authorize payment of benefits directly to EGL, with such benefits applied to my bill. I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me and I agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, not pre-certified or not preauthorized by my insurance plan. I understand that EGL is permitted to disclose my health information for purposes of payment of bills (if I filled out section 3 above), my continued care or treatment, and healthcare operations.

Signature of Patient, Parent, or Guardian: (Required) _____ Date ____/____/____

INTERNATIONAL SAMPLES

Payment in full must be made before samples will be processed. Prepaid samples may receive a discount when required payment is received with the sample. Please visit our website for more information: <http://geneticslab.emory.edu/billing/international>. Payment by credit card can be indicated under option 2 above. Banker's checks or money orders must be made payable to Emory Genetics Laboratory. Please contact the EGL billing office for further arrangements or when you make an electronic fund payment at 404-778-8580 or eglbilling@emory.edu.

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DISEASE SPECIFIC REQUISITIONS

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For sequential testing, indicate in the 'Order' column, the numerical order for testing to be processed. Example: (1) MCADD Mutation Panel, (2) MCADD Gene Sequencing indicates that (1) MCADD Mutation panel will be run first. If NEGATIVE, (2) MCADD Sequencing will be added.

Note: Call to discuss prenatal molecular genetic testing with the laboratory genetic counselor PRIOR to sending a prenatal sample. 5 ml maternal blood in an EDTA (purple top) tube MUST accompany a prenatal specimen.

BIOCHEMICAL GENETIC TESTING		
Order	Code	Congenital Disorders of Glycosylation - Biochemical
	BCDGP	N-glycan and Transferrin Panel
	OS	Oligosaccharide and Glycan Screening
	BCDGS	CDG Transferrin
	BNGLY	N-glycan Analysis for CDGs
	BOGLY	CDG: O-glycan only
Order	Code	Galactosemia (Comprehensive)
	GS	Galactosemia Panel (GALT activity and Gal-1-P) <i>If enzyme testing comes back abnormal and you would like to automatically reflex to GALT full gene sequencing, please select test code SG below.</i>
	GR	Galactosemia Carrier Panel (GALT Activity) <i>If enzyme testing comes back abnormal and you would like to automatically reflex to GALT full gene sequencing, please select test code SG below.</i>
	GL	Galactitol
	GT	Galactosemia: GALT Enzyme Activity
	GP	Galactose-1-Phosphate Profile
[] Seq	SG	Galactosemia - GALT gene
[] Del/Dup	DGALT	
Order	Code	Lysosomal Storage Disorders - Enzyme
	LS	Lysosomal Enzyme Panel (13 enzymes), Blood
Order	Code	Lysosomal Storage Disorders - Screening and Monitoring
	BLSDS	Lysosomal Storage Disease (LSD) Screen, Urine (GA, OS)
	GA	Mucopolysaccharide (MPS) Screen, Urine
	BM	Gaucher Biomarker Panel (ACE, CHITO, TRAP)
Order	Code	Metabolic and Analyte Studies
	MW	Genetic Metabolic Panel (AA, AR, CN, OA)
	AR	Acylcarnitine Profile
	ED	Amino Acids Analysis, CSF
	AA	Amino Acids Analysis, Plasma
	UA	Amino Acids Analysis, Urine
	BCAHP	CAH Profile, Dried Blood Spot
	CN	Carnitine Concentration Profile, Plasma
	UC	Carnitine Concentration Profile, Urine
	BCQLC	Coenzyme Q10, Leukocytes
	CQ	Coenzyme Q10, Plasma
	BHOBS	Homocysteine, Total, Dried Blood Spot
	HO	Homocysteine, Total, Plasma
	MQ	Methylmalonic Acid Quantitation, Plasma
	BMMAU	Methylmalonic Acid Quantitation, Urine
	BMMAD	MMA & MCA, Dried Blood Spot
	BMSUD	MSUD: Allo-isoleucine & BCAA, Dried Blood Spot
	BNBSF	NBS Follow-up: Elevated C3 (AA, AR, CN, OA, HO)
	OA	Organic Acids Quantitative Analysis
	OT	Orotic Acid Assay

Order	Code	Metabolic and Analyte Studies
	ZF	Pyruvic Acid, Blood
	ZE	Pyruvic Acid, CSF
	BSLOS	Smith-Lemli-Opitz Screen by MSMS
Order	Code	Other Enzyme Assays
	BX	Biotinidase Enzyme Activity
	ZU	Maple Syrup Urine Disease, BCKD Enzyme Activity, fibroblast
	BC	Maple Syrup Urine Disease, BCKD Enzyme Activity, Lymphoblast
Order	Code	STAT Biochemical Testing
	BARST	Acylcarnitine Profile (STAT) Must contact laboratory before receipt of sample.
	BAAST	Amino Acids Analysis, Plasma (STAT) Must contact laboratory before receipt of sample.
	BOAST	Organic Acids Quantitative Analysis (STAT) Must contact laboratory before receipt of sample.
CYTOGENETIC TESTING		
Order	Code	Chromosomal Microarray
	VA	EmArray Cyto
	CMSNP	CytoScan SNP Array
	CMPOC	CytoScan SNP Array POC (MCC not included but recommended- also order below if requested)
	CMCCS	Maternal Cell Contamination (MCC)
Order	Code	Chromosome Analysis
	CA	Peripheral Blood, Age: 6 months and above
	CB	Peripheral Blood, Age: less than 6 months
	MM	Peripheral Blood, Mosaicism study
	AD	Amniotic Fluid (includes AFP with reflex to ACHE)
	CV	Chorionic Villi
	CP	Fetal Blood (PUBS)
	CO	Products of Conception (EmArray Cyto POC recommended as first tier)
	FS	Targeted Family Member Study (attach report)
Order	Code	FISH STAT
	RS	Prenatal FISH - Aneuploidy (13,18, 21, X&Y)
	CFXYS	X and Y (ambiguous genitalia)
	CF22S	22q11 microdeletion (DiGeorge, VCF)
	CF13S	Trisomy 13
	CF18S	Trisomy 18
	CF21S	Trisomy 21
Order	Code	FISH Standard
	PA	FISH Analysis with Culture (Also indicate probe below, if probe not listed, check other)
	FI	FISH Analysis without Culture (Also indicate probe below, if probe not listed, check other)
		Array Confirmation/Family Studies Custom Other: _____
		Wolf-Hirschhorn (4p-)
		Cri-du-Chat (5p-)

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Note: Call to discuss prenatal molecular genetic testing with the laboratory genetic counselor PRIOR to sending a prenatal sample. 5 ml maternal blood in an EDTA (purple top) tube MUST accompany a prenatal specimen.

Order	Code	FISH Standard
		Williams (7q11.2 del)
		Prader-Willi/Angelman (Order after DNA methylation)
		Smith-Magenis (17p11.2 del)
		Miller-Dieker, lissencephaly (17p13)
		17q21 Microdeletion Syndrome
		22q11.2 deletion, DiGeorge/VCF (reflex test if heart defect on fetal u/s)
	TL	Telomere Panel
Order	Code	Other Cyto Tests
	TC	Tissue Culture
MOLECULAR GENETIC TESTING		
Order	Code	Ashkenazi Jewish Disease Screening
	AJ	Ashkenazi Jewish Carrier Screening Panel (DNA & Tay-Sachs Enzyme) *This testing is being updated and not currently available for testing until July 2013.*
	MAJSP	Ashkenazi Jewish Carrier Screening Panel: DNA Only *This testing is being updated and not currently available for testing until July 2013.*
Order	Code	Cardiac Disorders
	MCAR1	Cardiomyopathy Panel
[] Seq	SCACN	CACNA1C-Related Disorders - CACNA1C gene
[] Del/Dup	DCACN	
[] Seq	DK	Isolated Nonsyndromic Congenital Heart Disease - NKX2-5 gene
[] Del/Dup	KP	
[] Seq	SMAP1	MAP2K1-Related Disorders - MAP2K1 gene
[] Del/Dup	DMAP1	
[] Seq	SRYR2	RYSR2-Related Disorders - RYSR2 gene
[] Del/Dup	DRYR2	
[] Seq	STPM1	TPM1-Related Disorders - TPM1 gene
[] Del/Dup	DTPM1	
	STTNX	TTN-Related Disorders - TTN gene
Order	Code	Ciliopathies
	MCIL1	Ciliopathies Panel
Order	Code	Congenital Abnormality Syndromes
	MNOO1	Noonan Syndrome & Related Disorders Panel
	CC061	1q21.1 Del/Dup Analysis
[] Seq	SBLM1	Bloom Syndrome - BLM gene
[] Del/Dup	DBLM1	
[] Seq	SBRAF	BRAF-Related Disorders - BRAF seq
[] Del/Dup	DBRAF	
[] Seq	SMAP2	CFC syndrome, MAP2K2-Related - MAP2K2 gene
[] Del/Dup	DMAP2	
[] Seq	UH	CHARGE Syndrome - CHD7 Gene
[] Del/Dup	DCHD7	
[] Seq	SHRAS	Costello Syndrome - HRAS gene
[] Del/Dup	DHRAS	

Order	Code	Congenital Abnormality Syndromes
[] Seq	SKDM6	Kabuki Syndrome - KDM6A Full Gene Sequencing
[] Del/Dup	DKDM6	
[] Seq	SMLL2	Kabuki Syndrome - KMT2D gene
[] Del/Dup	DMLL2	
	MKABP	Kabuki Syndrome Panel - KMT2D and KDM6A seq and del/dup
[] Seq	ZG	KRAS-Related Disorders - KRAS gene
[] Del/Dup	DKRAS	
	SSPRE	Legius Syndrome: SPRED1 gene sequencing
[] Seq	SNRAS	Noonan Syndrome - NRAS gene
[] Del/Dup	DNRAS	
[] Seq	UG	Noonan Syndrome - PTPN11 gene
[] Del/Dup	DPTPN	
[] Seq	SSOS1	Noonan Syndrome - SOS1 gene
[] Del/Dup	DSOS1	
[] Seq	SRAF1	Noonan Syndrome: RAF1 gene
[] Del/Dup	DRAF1	
[] Seq	SSHOC	Noonan-Like Syndrome with Loose Anagen Hair - SHOC2 gene
[] Del/Dup	DSHOC	
[] Seq	SCREB	Rubinstein-Taybi Syndrome - CREBBP gene
[] Del/Dup	DCREB	
	SEP30	Rubinstein-Taybi Syndrome - EP300 gene sequencing
[] Seq	SDHCR	Smith-Lemli-Opitz Syndrome- DHCR7 gene
[] Del/Dup	DDHCR	
[] Del/Dup	DRAI1	Smith-Magenis Syndrome- RAI1 gene
[] Seq	SRAI1	
[] Seq	SNSD1	Sotos Syndrome - NSD1 gene
[] Del/Dup	DNSD1	
	XM060	TAR panel
	MS061	TAR Syndrome - RBM8A gene sequencing
Order	Code	Cornelia de Lange
[] Seq	SNIPB	Cornelia de Lange Syndrome- NIPBL gene
[] Del/Dup	DNIPB	
[] Seq	SSMC1	Cornelia de Lange Syndrome- SMC1A gene
[] Del/Dup	DSMC1	
Order	Code	Cystic Fibrosis
[] Seq	JK	Cystic Fibrosis - CFTR gene
[] Del/Dup	JL	
	CF	Cystic Fibrosis Common Mutation Panel
Order	Code	Eye Disorders
	MM030	Eye Disorders Panel
[] Seq	SBEST	BEST1-Related Disorders - BEST1 gene
[] Del/Dup	DBEST	
	MM032	Achromatopsia/Cone/Cone-Rod Dystrophy Panel
[] Seq	AF	Autosomal Dominant Optic Atrophy and Cataract - OPA3 gene
[] Del/Dup	KN	
[] Seq	DL	Autosomal Dominant Optic Atrophy, Kjer Type - OPA1 gene
[] Del/Dup	KO	

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Note: Call to discuss prenatal molecular genetic testing with the laboratory genetic counselor PRIOR to sending a prenatal sample. 5 ml maternal blood in an EDTA (purple top) tube MUST accompany a prenatal specimen.

Order	Code	Eye Disorders
	MM033	Central Areolar Choroidal Dystrophy/Chorioretinal Atrophy Panel
[] Seq	SCHMX	Choroideremia - <i>CHM</i> gene
[] Del/Dup	DCHMX	
	MM034	Congenital Stationary Night Blindness Panel
	SHPS1	Hermansky-Pudlak Syndrome - <i>HPS1</i> gene sequencing
[] Seq	SHPS4	Hermansky-Pudlak Syndrome - <i>HPS4</i> gene
[] Del/Dup	DHPS4	
	MM035	Leber Congenital Amaurosis Panel
	QC	Leber Hereditary Optic Neuropathy (LHON)
	MM036	Macular/ Pattern Dystrophies Panel
	MM037	Optic Atrophy Panel
	MM039	Other Eye Disorders Panel
[] Seq	SPAX6	<i>PAX6</i> -Related Disorders - <i>PAX6</i> gene
[] Del/Dup	DPAX6	
	MM031	Photoreceptor Dystrophy/Degeneration
	MM038	Retinitis Pigmentosa Panel
[] Seq	SRB1X	Retinoblastoma - <i>RB1</i> gene
[] Del/Dup	DRB1X	
[] Seq	SRP20	<i>RP2</i> -Related X-Linked Retinitis Pigmentosa - <i>RP2</i> gene
[] Del/Dup	DRP20	
	SDHDD	<i>RP59</i> - <i>DHDDS</i> gene sequencing
[] Seq	SRPGR	<i>RPGR</i> -Related X-Linked Retinitis Pigmentosa - <i>RPGR</i> gene sequencing
[] Del/Dup	DRPGR	
Order	Code	Growth Disorders
	XM010	Short Stature Panel - Comprehensive
	XM011	Short Stature Panel - SNP Array, NGS and Del/Dup
	MM011	Short Stature Panel - Russell-Silver Panel, NGS and Del/Dup
	MM012	Short Stature Panel - NGS & Del/Dup
	BW	Beckwith-Wiedemann Panel: <i>H19</i> & <i>Lit1</i> Methylation
	ZP	Beckwith-Wiedemann: <i>H19</i> Methylation
	BL	Beckwith-Wiedemann: <i>Lit1</i> Methylation
	NZ	Russell-Silver Panel - <i>H19</i> Methylation & UPD7
	NM	Russell-Silver Syndrome: UPD7
	RT	Russell-Silver: <i>H19</i> Methylation
	SSHOX	<i>SHOX</i> -Related Haploinsufficiency Disorders - <i>SHOX</i> gene sequencing
Order	Code	Hearing Loss
	HL	Hearing Loss Panel - Cx26 & 30 Sequencing, Cx30 Common Deletion, Mitochondrial HL
[] Seq	SX	Hearing Loss: <i>GJB2</i> & <i>GJB6</i> - gene panel
[] Del/Dup	PI	(Sequencing includes Cx30 common deletion)
	OZ	Hearing Loss - <i>GJB2</i> sequencing
	FL	Hearing Loss - <i>GJB6</i> Seq (Includes Cx30 common deletion)

Order	Code	Hearing Loss
	QJ	Mitochondrial Hearing Loss Common Mutations
	AT	Alpha-Thalassemia: <i>HBA1</i> and <i>HBA2</i> deletion analysis
	HS	Sickle Cell Disease - HbS/HbC Mutations
Order	Code	Infertility
	MG	Female Infertility Panel (Chromosomes, <i>FMR1</i> - Related POF)
	XM050	Male Infertility Panel (Chromosomes, CF common mutation panel, Y-Microdeletions)
	MFMR1	Premature Ovarian Insufficiency - <i>FMR1</i> CGG Repeat Analysis
	YD	Y-Chromosome Microdeletions for Infertility
Order	Code	Methylation Studies
	OO	Chromosome 14 Uniparental Disomy
	TU	Chromosome 6 Uniparental Disomy
	PW	Prader Willi/Angelman (order before <i>FISH</i>)
Order	Code	Mitochondrial Disease
	QB	CPEO
	ZO	Kearns-Sayre Syndrome
	QD	Leigh Disease
	QA	MELAS
	QH	MERRF
	ML	Mitochondrial Southern Blot for Deletions
	ZN	Pearson Marrow-Pancreas Syndrome
	QK	Retinitis Pigmentosa and Ataxia (NARP)
	JD	Mitochondrial Full Genome Sequencing (one of above tests recommended first, if indicated)
Order	Code	Movement Disorders
	SSETX	Ataxia with Oculomotor Apraxia Type 2 - <i>SETX</i> gene sequencing
	FJ	Fragile X-Associated Tremor/Ataxia (FXTAS) - CGG Repeat Analysis
	HT	Huntington Disease - CAG Repeat Analysis (Requires Consent)
	SAT7B	Wilson Disease: <i>ATP7B</i> gene sequencing
Order	Code	Seizure Disorders
	MEP11	Epilepsy and Seizure Disorders Panel
	SGABR	Childhood Absence Epilepsy - <i>GABRB3</i> gene
[] Seq	SPNKP	Early Infantile Epileptic Encephalopathy Type 10 - <i>PNKP</i> gene
[] Del/Dup	DPNKP	
[] Seq	SSLC2	Glucose Transporter Type 1 Deficiency Syndrome- <i>SLC2A1</i> gene
[] Del/Dup	DSLC2	
[] Seq	SRELN	Lissencephaly 2 - <i>RELN</i> gene
[] Del/Dup	DRELN	
Order	Code	Sex Determination
	DY	Y-Chromosome Detection

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Order	Code	Skin Disorders
	SMSMO	<i>MSMO1</i> -Related Psoriasiform Dermatitis - <i>MSMO1</i> gene sequencing
[] Seq	SZMPS	<i>ZMPSTE24</i> -Related Disorders - <i>ZMPSTE24</i> gene
[] Del/Dup	DZMPS	
Order	Code	Twin Zygosity
	ZT	Twin Zygosity Testing
Order	Code	Known Mutation Analysis
	KM	Known Mutation Testing (<i>Please indicate mutation/s information on page 1</i>)
	DKMDD	Known Mutation Testing for Del/Dup (<i>Please indicate mutation/s information on page 1</i>)
Order	Code	OTHER
[] Seq	SFOXG	Congenital Variant Rett Syndrome- <i>FOXG1</i> gene
[] Del/Dup	DFOXG	
Order	Code	OTHER TESTS
		Other Test (<i>Please Specify</i>): _____