Saint Francis Health System Center for Genetics at Saint Francis
Shipping Address: 6161 South Yale Avenue • Tulsa, OK 74136
(918) 502-1720 Phone • (918) 502-1723 Fax • (866) 846-0315 Toll Free
www.saintfrancisgenetics.com

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Federal Tax # 73-0700090
Medicare # 370091
CLIA # 37D0474681
CAP # 2050201

MOLECULAR GENETICS LABORATORY TEST REQUISITION

411-001K front / 07-12

PATIENT / SPECIMEN INFORMATION

PATIENT NAME - *LAST, FIRST, MI*	☐ M ☐ F	SSN OR MRN	DATE OF BIRTH

RACE	DIAGNOSIS - *INDICATIONS FOR TESTING*

ICD9	SPECIMEN TYPE	COLLECTION DATE	TIME	CONSENT OBTAINED
				☐ Yes ☐ No

REFERRAL SOURCE

REQUESTING / CONTACT PHYSICIAN	**REQUESTING PHYSICIAN / PRACTITIONER SIGNATURE - (REQUIRED BY MEDICARE)**

PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE	PHONE NUMBER	FAX RESULTS **FAX** NUMBER
		☐ No ☐ Yes

REFERRING FACILITY

FACILITY ADDRESS, CITY, STATE, ZIP - *IF DIFFERENT FROM ABOVE*	PHONE NUMBER	FAX RESULTS **FAX** NUMBER
		☐ No ☐ Yes

ADDITIONAL REPORTS TO

MOLECULAR GENETICS TESTS

☐ Achondroplasia (targeted FGFR3 - G380R)	☐ Hearing Loss - Waardenberg, type 2 (MITF)	☐ Spinocerebellar Ataxia, Type 2 (SCA2)
☐ Albright Hereditary Osteodystrophy (Complete GNAS1 gene)	☐ Hearing Loss - Waardenburg Syndrome panel (PAX3 & MITF)	☐ Spinocerebellar Ataxia, Type 3 (SCA3; MJD)
☐ ALS (Complete SOD1 gene)	☐ Hepatitis B by PCR - Quantitative	☐ Spinocerebellar Ataxia, Type 6 (SCA6)
☐ Androgen Insensitivity Syndrome (Complete AR gene)	☐ Hepatitis C by PCR - Quantitative	☐ Spinocerebellar Ataxia, Type 7 (SCA7)
☐ Angelman Syndrome (Methylation)	☐ Hepatitis C by PCR - Genotyping	☐ Spinocerebellar Ataxia Panel (SCA1, 2, 3, 6, & 7)[3]
☐ Apert's Syndrome (FGFR2 - exon 8)	☐ Huntington Disease (HD)[4]	☐ Waardenberg Syndrome Panel (PAX3 & MITF)
☐ BRAF (codon 600)	☐ Hypochondroplasia (targeted FGFR3, N540K))	☐ Waardenberg Syndrome, type 1 & 3 (Complete PAX3 gene)
☐ Beare - Stevenson Syndrome (targeted FGFR2 - exons 8,10,11)	☐ Hypotonia Panel (DM, PWS, SMA)[3]	☐ Waardenberg Syndrome, type 2 (Complete MITF gene)
☐ Blau Syndrome (NOD2/CARD15 Complete gene)	☐ JAK2 (V617F)	☐ Other:
☐ Congenital Adrenal Hyperplasia[6] (21-hydroxylase deficiency)	☐ K-ras[5] (codons 12 and 13)	
☐ Connexin 26 gene (GJB2 Locus - Hearing Loss)	☐ Li-Fraumeni Syndrome (Complete TP53 gene)	
☐ Connexin 30 gene (GJB6 Locus - Hearing Loss)	☐ Marfan Syndrome (complete FBN1 gene)	
☐ Craniodysmorphology Screen (targeted FGFR 1, 2, & 3)	☐ Marfan Syndrome - known mutation (FBN1)	
☐ Craniodysmorphology Panel (targeted FGFR & TWIST)[3]	☐ Marfan Syndrome, Type 2 - (TGFBR1) gene	**OTHER SERVICES**
☐ Crohn's Disease (NOD2/CARD15 Complete Gene)	☐ Marfan Syndrome, Type 2 - (TGFBR2) gene	☐ Nucleic Acid Extraction
☐ Crohn's Disease (NOD2 susceptibility markers)	☐ Marfan Syndrome, Type 2 Panel (TGFBR1 and TGFBR2)	☐ Sequencing - known mutation (include report)
☐ Crouzon Syndrome with Acanthosis Nigricans (FGFR3 - A391E)	☐ Maternal Cell Contamination[7]	☐ Tier Testing
☐ Cystic Fibrosis	☐ McCune - Albright Syndrome[5] (GNAS1 - R201 only)	
☐ DRPLA	☐ Mitochondrial Hearing Loss - mt A1555G mutation	
☐ Dwarfism Panel[3] (Achondroplasia & Hypochondroplasia)	☐ Mitochondrial Hearing Loss - MTTS1	
☐ EGFR Mutation Analysis[5] (targeted exons 18-21)	☐ MTHFR	
☐ EGFR Mutation Analysis[5] (Reflexed to ALK-FISH))	☐ Muenke Syndrome (only FGFR3 - P250R)	
☐ Factor V Leiden	☐ Myotonic Dystrophy	
☐ FGFR Screen (targeted FGFR1, 2, & 3)	☐ Neurological Panel (HD, SCA, FRDA, DRPLA)[3]	
☐ FGFR2 Complete Gene (Reflex from Craniodysmorphology Tests)	☐ NOD2/CARD15 gene (Crohn's Disease) (4 Susceptibility Markers)	
☐ Fragile X Syndrome	☐ NOD2/CARD15 Complete Gene Analysis	
☐ Friedreich's Ataxia (FRDA)	☐ Nonsyndromic Craniodysmorphoiogy (Muenke Syndrome)	
☐ FTDP (Pick Disease; Tauopathy; MAPT) - exon 10 only	☐ P53 (Li Fraumeni Syndrome)	
☐ FTDP (MAPT Complete gene)	☐ Pendred Syndrome (Complete SLC264A4 gene)	
☐ GNAS1 complete gene (AHO, PHP1a)	☐ Pick Disease (FTDP) - exon 10 only	
☐ GRN Complete gene (PGRN, Granulin)	☐ Pick Disease (MAPT Complete gene)	
☐ Hearing Loss (Connexin26)	☐ Polycystic Kidney Disease (PKD1 Linkage)[2]	
☐ Hearing Loss (Connexin30)	☐ Polycystic Kidney Disease (PKD2 Linkage)[2]	
☐ Hearing Loss - CX Panel (CX26 & CX30)[3]	☐ PKD Linkage - known allele (include report)	
☐ Hearing Loss - Full Panel (Cx26&30, mt1555)[3]	☐ Prader-Willi Syndrome (Methylation)	
☐ Hearing Loss - Mitochondrial Mutation A1555G	☐ Prothrombin	
☐ Hearing Loss - Mitochondrial Panel (mtA1555G & MTTS-1)	☐ Pseudohypoparathyroidism (GNAS1)	
☐ Hearing Loss - MTTS1	☐ Saethre-Chotzen Syndrome (TWIST)	
☐ Hearing Loss - Pendred Syndrome (SLC26A4)	☐ SOD1 (ALS, Lou Gehrig's Disease)	
☐ Hearing Loss - Waardenberg, type 1 & 3 (PAX3)	☐ Spinal Muscular Atrophy, Types 1, 2, & 3 (SMA)	

2 Cannot be performed on a specimen from a single patient. Family Study, Pedigree REQUIRED
3 Discounted Panel of Tests
4 Consent form MUST accompany specimen (Pre-Symptomatic Patient)
5 Special Instructions : Please Call Laboratory
6 Testing of Parents is STRONGLY recommended when testing prenatal samples
7 REQUIRED for all prenatal testing

CENTER FOR GENETICS AT SAINT FRANCIS USE ONLY

DATE RECEIVED	TIME	TYPE / AMOUNT RECEIVED	ACCESSION NUMBER

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BILLING INFORMATION

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PAYMENT INFORMATION - *INDICATE ONE*

☐ **SELF PAY (Payment in Full from Patient or Guarantor)**

☐ Check or Money Order Payable to Saint Francis Hospital

☐ Credit Card ☐ VISA ☐ MC ☐ AE		CARDHOLDER NAME - *PRINT*	ZIP CODE
ACCOUNT NUMBER	EXPIRATION DATE / SECURITY NO.	CARDHOLDER - *SIGNATURE*	

Payment for Medical Care: It is understood and agreed that the undersigned or a designated agent will be responsible and assume an obligation to pay the Center for Genetics at Saint Francis all costs for genetic evaluation and testing rendered to the person whose name appears within thirty (30) days after having been notified of the amount due and owing or will work out a satisfactory payment plan with the Center for Genetics at Saint Francis. It is further understood and agreed that the undersigned or designated agent will, at all times, remain responsible for the costs of said genetic evaluation and testing.

PATIENT SIGNATURE - *MUST BE 18 YEARS OR OLDER TO SIGN*	DATE
PARENT / LEGAL GUARDIAN - *REQUIRED IF PATIENT IS LESS THAT 18 YEARS OF AGE OR IS NOT LEGALLY COMPETENT*	
ADDRESS, CITY, STATE, ZIP	HOME PHONE NUMBER ( )
EMPLOYER	WORK PHONE NUMBER ( )
WITNESS - *SIGNATURE*	DATE

☐ **INSURANCE (Filed as Courtesy - Patient Ultimately Responsible for Balance of Account)**
SUBMIT ALL OF THE INFORMATION BELOW WITH FRONT AND BACK COPY OF CARD AND REQUIRED AUTHORIZATION. INCOMPLETE SUBMISSIONS COULD DELAY TESTING. FOR OUT OF STATE PATIENTS, THE ONLY BILLABLE PLANS ARE AETNA, BLUE CROSS BLUE SHIELD, UNITED HEALTHCARE, AND CIGNA.

POLICY HOLDER NAME		POLICY HOLDER SOCIAL SECURITY NUMBER	POLICY HOLDER DATE OF BIRTH
ADDRESS, CITY, STATE, ZIP			HOME PHONE NUMBER ( )
EMPLOYER			WORK PHONE NUMBER ( )
PRIMARY CARE PHYSICIAN		PHYSICIAN NPI NUMBER	
INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE	POLICY NUMBER	GROUP NUMBER
INSURANCE COMPANY ADDRESS, CITY, STATE, ZIP CODE			
REFERRAL NUMBER	REFERRAL DATE	EFFECTIVE DATE	AUTHORIZATION NUMBER
MEDICARE NUMBER		MEDICAID NUMBER (OKLAHOMA ONLY)	

Authorization to Release Protected Health Information, Assign Benefits, and Accept Responsibility for My Account: I authorize any physician or laboratory who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Center for Genetics at Saint Francis. I understand that I am responsible for any co-pay or deductible amounts if the Center for Genetics at Saint Francis is a participant in my health plan. I understand I am fully responsible for payment of my account if the Center for Genetics at Saint Francis is not a participant with my health plan, and my health plan does not reimburse (or only partially reimburses) my medical services due to lack of authorization or medical necessity. **The information permitted for release may include records which indicate the presence of a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS), and/or mental health information.**

PATIENT / GUARANTOR - ***SIGNATURE***	DATE

☐ **REFERRING FACILITY**

FACILITY NAME	PHONE NUMBER ( )	FAX NUMBER ( )
BILLING ADDRESS		APPROVAL NUMBER - *IF APPLICABLE*