



Patient Information

Patient First Name: _____ MI _____ Last Name _____
 Gender: Male Female
 Date of Birth: (mm/dd/yy) _____
 Patient Address: Street _____ Apt # _____
 City/State/Zip Code _____
 Patient Phone: Home _____ Work Phone _____
 Medical Record Number _____

Ordering Physician Information

Physician/Genetic Counselor _____
 NPI # _____
 Specialty (Example: Genetics or Cardiology) _____
 Institution _____
 Street Address _____
 City/State/Zip Code _____
 Phone _____ Fax _____ Email _____
 Signature _____

Clinical Diagnosis

ICD-9 codes

425.1: Hypertrophic cardiomyopathy, Idiopathic
 425.4: Cardiomyopathy, Familial
 425.7: Metabolic Cardiomyopathy
 425.8: Syndromic Cardiomyopathy
 426.82: Long QT syndrome
 427.9: Cardiac dysrhythmia, unspecified

427: Cardiac Dysrhythmias
 427.4: Ventricular Fibrillation with prolonged QT
 746.89: Brugada Syndrome
 794.31: Abnormal EKG
 V18.9: Family member is a carrier of a genetic disease
 Other: _____

Patient Consent

I have read the Informed Consent document and I give permission to GeneDx to perform genetic testing as described.

I also give permission for my specimen and clinical information to be used in cardiology and/or genetic research studies. My name will not be used in any research studies, and it will not be possible to link results of research studies back to my specimen.

Check this box, if you wish to opt out of research studies.

I will cooperate fully with GeneDx by providing all necessary documents needed for insurance billing and appeals. I understand that I am responsible for sending GeneDx any and all of the money that I receive directly from my insurance company in payment for this test.

Patient Sign Here: _____

Clinical Information

Age at diagnosis: _____ Years Ethnicity: _____
 Family member(s) affected: Yes No
 Relationship(s): _____
 Syncope Yes No Number of Episodes _____
 Cardiac Arrest/SCD Yes No

Patient's Diagnostic Tests (Please provide copies)

Electrocardiogram	Maximum QTc interval _____ msec
Echocardiogram	Maximum LV wall thickness: _____ mm EF% _____ Left ventricular internal diastolic dimension: _____ mm
Cardiac MRI	Maximum LV wall thickness: _____ mm EF% _____ Left ventricular internal diastolic dimension: _____ mm
RV fatty infiltrate	<input type="checkbox"/> Yes <input type="checkbox"/> No

Cardiology Genetic Testing Panels

Sequencing Tests

Hypertrophic Cardiomyopathy (17 Genes)
 ACTC1, CAV3, GLA, LAMP2, MTTG, MTTI, MTTK, MYBPC3, MYH7, MYL2, MYL3, PRKAG2, TNNC1, TNNI3, TNNT2, TPM1, TTR

Dilated Cardiomyopathy (23 Genes)
 ACTC1, DES, LAMP2, LMNA, MTND1, MTND5, MTND6, MTTH, MTTK, MTTLI, MTTQ, MTTSI, MTTSS2, MYBPC3, MYH7, PLN, SGCD, TAZ, TNNI3, TNNT2, TPM1, TTR, ZASP

Long QT Syndrome (10 Genes)
 ANK2, CACNA1C, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, SCN4B, SCN5A

Brugada Syndrome (5 Genes)
 CACNA1C, CACNB2, GPD1L, SCN1B, SCN5A

Arrhythmogenic Right Ventricular Cardiomyopathy (7 Genes)
 DSC2, DSG2, DSP, JUP, PKP2, RYR2, TMEM43

Catecholaminergic Polymorphic Ventricular Tachycardia (2 Genes)
 CASQ2, RYR2

Testing for a previously identified familial mutation

Gene: _____ Mutation: _____
 Proband Name: _____
 Proband GeneDx Accession #: _____
 Relationship to proband: _____

Deletion/duplication tests

Long QT Syndrome (10 Genes)
 ANK2, CACNA1C, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, SCN4B, SCN5A

Cardiomyopathies (20 Genes) Research use only*
 ACTC1, CAV3, GLA, LAMP2, MYBPC3, MYH7, MYL2, MYL3, PRKAG2, TNNC1, TNNI3, TNNT2, TPM1, TTR, DES, LMNA, PLN, SGCD, TAZ, ZASP

Arrhythmogenic Right Ventricular Cardiomyopathy (7 Genes) Research use only*
 DSC2, DSG2, DSP, JUP, PKP2, RYR2, TMEM43

Other Arrhythmic disorders (7 Genes) Research use only*
 CACNA1C, CACNB2, GPD1L, SCN1B, SCN5A, CASQ2, RYR2

*Except for Long QT syndrome, the clinical significance of del/dup testing is currently unknown.

Specimen Information

Date obtained: _____

2-5 ml whole blood in EDTA in one lavender/purple top tube
 DNA from _____ (tissue type?) (Concentration: _____ µg/mL)
 Other: _____



Please complete the form below to indicate how you would like GeneDx to bill

Institutional Bill

GeneDx Account # _____

Hospital/Lab Name _____

Contact Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Please send a duplicate report to this address

BILLING STAMP

Commercial Insurance Bill

I have prior authorization # _____

Name of Insured _____ Date of Birth _____

Relationship to Insured Self Spouse Child Other

Insurance Carrier _____

ID # _____

Group # _____ Policy Name _____

SSN # _____

Please include a copy of the front and back of the patient's insurance card.
GeneDx will bill the insurance and appeal for payment on patient's behalf. The patient getting the full sequencing or del/dup panel will be responsible for any co-pay, co-insurance and unmet deductible amounts that their policy dictates. The patient responsibility will be limited to \$500* for sequencing and \$250* for del/dup testing. For insurance billing questions, please contact our Patient Advocacy department at (301) 519-2100 x6727. Credit card information is required for family member testing. The cost of family member testing is \$350/mutation/patient.

I would like GeneDx to bill my credit card for the co-pay and unmet deductible amounts

Name as it appears on card _____

MasterCard Visa Discover American Express

Account Number _____ Expiration date _____ CVC _____

Signature _____ Date _____

* Except in New York where the waiver or reduction of co-pay, co-insurance and unmet deductible will be determined based on patient's financial need.

Patient Bill

I understand that my credit card will be charged the full amount for the testing.

Please bill my credit card (all major cards accepted)

Name as it appears on card _____

MasterCard Visa Discover American Express

Account Number _____

Expiration date _____ CVC _____

Amount _____

Signature _____ Date _____

GeneDx provides a financial assistance program or hardship discount for patients who do not have commercial insurance and cannot afford to pay out of pocket. Please call us at (301) 519-2100 x 6106



My signature of informed consent certifies that I have been provided with the following facts about the cardiology genetic test for which I am giving permission. I have had the opportunity to discuss the benefits, risks and limitations of this testing and I have had any questions answered.

Why is this test performed?

1. Many genetic diseases are caused by small mutations, or changes in one or more of an individual's genes. On the other hand, some genetic disorders are caused by a deletion or duplication of a larger section of a gene, or of the entire gene itself. Genetic diseases can be caused by both small and large mutations.
2. In Cardiology genetic test by sequencing [my/my child's] DNA will be studied to see if a small change or mutation has occurred in a gene or genes associated with heart structure and function. Sequencing test cannot be expected to identify large deletions or duplications in the genes tested, or any changes (small or large) in genes not included in this test. Large deletions and duplications at exon-level can be detected by del/dup test.
3. I understand that this test is performed to determine if I and/or members of my family have a mutation in a gene associated with a specific genetic disease, and whether I am/we are affected with, or at an increased risk to someday be affected with this genetic disease.
4. This test is not the only way to look for changes in my DNA and my physician may recommend this test before or after ordering other genetic and/or cardiology tests.

What might I find out from this test?

5. I might learn that no change (mutation) was found in the gene(s) studied. This outcome does not mean that [I do not/my child does not] have a genetic disease.
6. I might learn that a specific gene or genes do have a change (mutation), thus explaining the cause of the disorder that I already know [I have/my child has] already been diagnosed with.
7. I might learn that a gene change was found in my gene(s) that is associated with possible long term medical problems that I do not already know about. My physician will be informed of any long term risks that may be associated with the findings of this test, according to current medical understanding.
8. I might learn that I have a gene change (gene variant) whose clinical consequences, or relationship to medical problems is currently unknown. The variant could be a normal change in the gene, or could be disease-causing mutation. Without further information, the effects of the variant may not be known and an inconclusive result may be reported.
9. When a gene variant is found, it is important to find out if the gene variant (change) is also found in other family members. Testing the biological parents of the affected individual, and/or testing other affected family members may be necessary to determine if the gene variant is disease-causing or a normal genetic change.

What are the limitations of the test?

10. In some cases, genetic tests are unable to identify a change in a gene even though the change may still exist. This event may be due to the current lack of knowledge about a gene's complete structure, or due to the fact that there may be other genes associated with a disease that have not yet been identified. In other cases, there is an inability of the current technology (test method), to identify certain types of changes in the gene(s).
11. An error in the diagnosis of a disease may occur if the true biological relationships of the family members being tested are not as stated. This is particularly important when parents of an affected child are submitted to the laboratory for testing. For example, non-paternity means that the stated father of an individual is not the true biological father. This test may detect non-paternity, and it may be necessary to report this finding to the individual(s) who requested testing. Non-disclosure regarding any non-biological relationships may result in incorrect result interpretation, incorrect diagnoses in the family members and/or inconclusive test results.
12. I understand that the genetic test performed by GeneDx is specific for this disease and in no way guarantees my health or the health of my living or unborn children. This test does not have the ability to detect all of the long-term medical risks that [I/my child] might experience. The accuracy of genetic testing is dependent on the clinical diagnosis made elsewhere, and GeneDx cannot be responsible for incorrect clinical diagnoses.

Permission for research studies

- I give permission for my submitted specimen and/or clinical information to be used in cardiology and/or genetic research studies. My name will remain confidential and will not be used in any research studies.

Because of the complexity of genetic testing and the important implications of the information received from testing, results will only be reported to me through a physician, genetic counselor or another certified genetics/cardiology professional. The result reports are confidential and will only be released to other medical professionals or other parties with my express written consent. Participation in genetic testing is completely voluntary.

Informed Consent

Sign here or on Page 1 of the Sample Submission (Order) Form.

Patient or Guardian's Signature: _____ **Date:** _____