



**Patient information**

\_\_\_\_\_  
First name Last name

Gender:  Female  Male  Unknown

\_\_\_\_\_  
Date of birth (mm/dd/yy)

\_\_\_\_\_  
Mailing address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Home phone Work Phone

**Reporting Address**

\_\_\_\_\_  
Physician / Genetic counselor

\_\_\_\_\_  
Mailing address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone Fax (Important)

\_\_\_\_\_  
Beeper Email

**Sample information**

\_\_\_\_\_  
Medical record # Specimen ID#

\_\_\_\_\_  
Date sample obtained (mm/dd/yy)

**Sample Type** (Note: only ONE specimen is required for multiple tests)

blood in EDTA (lavender top - one tube of 1-5ml)

buccal brushes (must be GeneDx kits)

skin punch biopsy, size \_\_\_\_\_ mm

DNA \_\_\_\_\_ (source?) \_\_\_\_\_ (ug/ml)

fetal sample \_\_\_\_\_ (tissue source?)

**Duplicate Report Address**

\_\_\_\_\_  
Physician / Genetic counselor

\_\_\_\_\_  
Mailing address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone Fax (Important)

\_\_\_\_\_  
Beeper Email

**ExonArrayDx: Gene-specific deletion/duplication testing by high-resolution microarray CGH**

Deletion/duplication testing of individual genes at the exon level. Consult ExonArrayDx gene list at [www.genedx.com](http://www.genedx.com) and write gene or disorder below.

Deletion/duplication testing for \_\_\_\_\_ (fill in genes, disorders, or gene panel to be tested)

**Expedited testing.** I would like expedited testing for this reason:

- Pregnancy (gestational age: \_\_\_\_\_ weeks)
- Transplantation
- Other \_\_\_\_\_

**Purpose**

- Diagnosis**
- Carrier test**
- Presymptomatic/predictive**

**For inherited metabolic disorders:**

- Enzyme assay positive  Yes  No  Not done
- Newborn screen positive  Yes  No

**Clinical diagnosis and family history**

**For office use only:**

**Ordering Checklist**

- Sample submission form  Completed payment option form (page 3)
- Informed consent (if appropriate)  Specimen tube, appropriately labeled

# Informed Consent for ExonArrayDx Testing

**My signature below or on page 1 of the Sample Submission Form indicates that I have been informed of these following facts about the ExonArrayDx test and I have had the opportunity to have any questions answered.**

## Why is this test done?

1. In the ExonArrayDx test [my / my child's] DNA will be studied to evaluate an entire gene or genes to see if the number of copies is lower or higher than usual.
2. Many genetic diseases and syndromes are caused by a deletion or duplication of a section of a gene or the entire gene itself.
3. On the other hand, many genetic disorders are caused by changes in genes other than in their copy number, and this test cannot be expected to diagnose those changes.
4. This test is not the only way to look for genetic changes, and my physician may recommend this test before or after doing other genetic tests.

## What might I find out from this test?

5. I might learn that no gene duplications or deletions were found. This outcome does not mean that [ I / my child] does not have a genetic disease.
6. I might learn that a specific gene or a part of a gene is duplicated or deleted, explaining the cause of a disorder that I already know [ I have / my child has ].

## Limitations of this test

7. This test does not have the ability to detect all long-term medical risks [ I / my child ] might experience.
8. Some regions within genes may have duplications or deletions that do not cause medical problems. They may be normal genetic variations between individuals.
9. I understand that the DNA analysis performed by GeneDx is specific for a suspected disorder specified by my physician or genetic counselor, and in no way guarantees my health or the health of my living or unborn children. GeneDx cannot be responsible for erroneous clinical diagnoses made elsewhere.
10. The clinical sensitivity of this test varies by the disorder tested for. Some disorders have a higher frequency of deletions and duplications compared to others. The sensitivity information is available for some genes but not for all tested genes.
11. This test cannot identify DNA changes that are very small (1 to roughly 150 nucleotides) and cannot delineate deletions or duplications that extend beyond the length of a tested gene.

Because of the complexity of DNA-based testing and the important implications of the test results, results will only be reported to me through a physician, genetic counselor, or another certified genetics professional. The result reports are confidential and will only be released to other medical professionals or other parties with my express written consent. All laboratory data is confidential and will not be released from GeneDx. Participation in DNA testing is completely voluntary.

**Sign here or on the Sample Submission (Order) Form.**

Signature: X Date: \_\_\_\_\_

# Payment Options

## I. Institutional Billing Information:

GeneDx Account # \_\_\_\_\_

Hospital/Lab Name \_\_\_\_\_

Contact Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

BILLING STAMP

## 2. Payment by credit card

*The full amount of the test fee is charged at the time of sample submission.*

\_\_\_\_\_

Name as it appears on card

\_\_\_\_\_

Billing address

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

\_\_\_\_\_

Phone

Mastercard  Visa  Discover  American Express

\_\_\_\_\_

Account number

\_\_\_\_\_

Expiration date (mm/yyyy) \_\_\_\_\_ 3/4-digit security code \_\_\_\_\_

Please bill my credit card in the amount of \$ \_\_\_\_\_ for diagnostic laboratory tests performed by GeneDx, Inc.

**X** \_\_\_\_\_

Signature (Required) \_\_\_\_\_ Date \_\_\_\_\_

## 4. Insurance Billing:

**GeneDx cannot bill Medicare. GeneDx does not participate in any Medicaid/Medical program.**

**GeneDx does not bill insurance companies directly unless all of the following is submitted:**

- Credit card information (complete part 2) to which any outstanding balance may be billed;
- An authorization number or letter of agreement from the insurance company.
  - The letter of agreement should be directed to GeneDx
  - detail the reimbursement rate
  - the name of the department or individual to whom the bill will be sent (including address, phone and fax numbers)
  - the patient's name and policy number.
- Copy of both sides of the insurance card.
- ICD9 codes (to be provided by physician) \_\_\_\_\_

I UNDERSTAND THAT I AM RESPONSIBLE IN ALL CASES FOR ALL FEES THAT ARE NOT COVERED BY INSURANCE.

**X** \_\_\_\_\_

Signature (Required)

## Note

IF YOU plan to apply on your own to your insurance carrier for reimbursement of your expenses for this test, the following information may be helpful in the case that GeneDx is requested by the carrier to prepare supporting documentation for you to use in your insurance claim:

Insurance Carrier \_\_\_\_\_

Is this a Blue Cross/Blue Shield Plan?  YES  NO

Subscriber Name \_\_\_\_\_

Is this a Medicaid plan?  YES  NO

Subscriber DOB \_\_\_\_\_

## 3. Payment by check or money order:

*Minimum of 75% of the cost of the test is required at the time of sample submission\*, with the remainder of the fee billed at the time of test completion.*

Check or money order enclosed in the amount of \$ \_\_\_\_\_.

**\* For patients from outside the United States, 100% of the fee is due at the time of sample submission**