

All sections on this page are required unless otherwise specified. Important fields are highlighted. Incomplete information could result in a delay of testing.

PATIENT INFORMATION

First Name		Last Name	
Sex Assigned at Birth: <input type="radio"/> Male <input type="radio"/> Female		Date of Birth (mm/dd/yy)	
Patient Karyotype (if known): _____		Gender Identification (optional): _____	
Email			
Address			
City	State	Zip Code	
Primary Phone	Is this patient deceased? <input type="radio"/> Yes <input type="radio"/> No Deceased Date: _____		

SAMPLE INFORMATION

Date Sample Collected (mm/dd/yy)		Medical Record #	
<input type="radio"/> Blood in EDTA (for CMA; purple top - single tube of 2-5 mL) <input type="radio"/> Blood in sodium heparin (for FISH; green top - single tube of 2-5 mL) <input type="radio"/> Buccal Swab <input type="radio"/> Other (specify source): _____			
<input type="checkbox"/> Treatment-related RUSH (optional)			
Reason: <input type="radio"/> Transplantation <input type="radio"/> Pregnancy (gestational age _____ weeks) <input type="radio"/> Other: _____			
Patient has had a blood transfusion <input type="radio"/> Yes <input type="radio"/> No Date of Last Transfusion: _____ (2-4 weeks of wait time is required for some testing)			
Patient has had an allogeneic bone marrow transplant <input type="radio"/> Yes <input type="radio"/> No <i>Fibroblasts are required for patients who had an allogeneic bone marrow transplant. See www.genedx.com/specimen-requirements for details.</i>			
If other samples are submitted:			
Relationship to patient	Name	Sample Type	
Relationship to patient	Name	Sample Type	

PATIENT CONSENT

By signing this form, I acknowledge as the patient or relative being tested that I have read or have had read to me the GeneDx Informed Consent document at the end of this test requisition form, and understand the information regarding molecular genetics testing. I have had the opportunity to ask questions about the testing, the procedure, the risks, and the alternatives. By signing this form, I authorize GeneDx to perform genetic testing as ordered. I understand that, for tests that evaluate data from multiple family members concurrently, test results from these family members may be included in a single comprehensive report that will be made available to all tested individuals and their healthcare providers.

By checking this box, I confirm that I am a New York State resident, and I give permission for GeneDx to retain any remaining sample longer than 60 days after the completion of testing, and to be used as a de-identified sample for test development and improvement, internal validation, quality assurance, and training purposes. Otherwise, New York law requires GeneDx to destroy my sample within 60 days, and it cannot be used for test development studies.

Check this box if you wish to opt out of being contacted for research studies

Signature of Patient/Legal Guardian (required)	Date
Signature of Relative A/Legal Guardian	Date
Signature of Relative B/Legal Guardian	Date

FOR COMMERCIAL INSURANCE ONLY:
By entering my preferred contact information below, I give my permission to GeneDx to contact me with an estimate of the patient's financial responsibility for testing. Data rates may apply.

Email (required)*	Mobile Number
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*Contact information provided must be for the individual authorizing the genetic testing.

ACCOUNT INFORMATION

GeneDx Account Number		Account Name	
Phone		Fax	
Address			
City	State	Zip Code	
Ordering Provider Name			Role/Title
NPI		Phone Number	
Send Report Via: <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Portal			
Fax #/Email: _____			
Additional Ordering Provider Name (optional)			Role/Title
NPI			
Send Report Via: <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Portal			
Fax #/Email: _____			
SEND ADDITIONAL REPORT COPIES TO (optional)			
Provider Name		GeneDx Acct#	
Fax #/Email: _____			

STATEMENT OF MEDICAL NECESSITY

By submission of this test requisition and accompanying sample(s), I: (i) authorize and direct GeneDx to perform the testing indicated; (ii) certify that the person listed as the ordering provider is authorized by law to order the test(s) requested; (iii) certify that any custom panel and/or ordered test(s) requested on this test requisition form are reasonable and medically necessary for the diagnosis and/or treatment of a disease, illness, impairment, symptom, syndrome or disorder; (iv) the test results will determine my patient's medical management and treatment decisions of this patient's condition on this date of service; (v) have obtained this patient's and relatives', when applicable, written informed consent to undergo any genetic testing requested; and (vi) that the full and appropriate diagnosis code(s) are indicated to the highest level of specificity.

Signature of Ordering Provider	Date
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ICD-10-CM CODES

ICD-10-CM Codes	
Clinical Diagnosis	Age of Onset

PAYMENT OPTIONS (Select One)

<input type="radio"/> INSURANCE BILL	Patient Status			
	Select all that apply <input type="radio"/> Hospital outpatient <input type="radio"/> Hospital inpatient; Date of Discharge: _____ <input type="checkbox"/> Not a hospital patient			
	Name of Insurance Carrier	Insurance ID#:		
	Relationship to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other: _____			
	Policy Holder's Name	Policy Holder's Date of Birth		
	Referral/Prior Authorization # (please attach)	<input type="checkbox"/> Hold test for cost estimate and contact patient if estimate is >\$250 (commercial insurance only)		
	Secondary Insurance Type:			
	Insurance Carrier	Insurance ID #	Subscriber Name	Date of Birth
	Relationship to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other: _____			
	<input type="radio"/> PATIENT BILL	If Patient Bill is selected, I am electing to be treated as a self-pay patient for this testing. I agree that neither GeneDx nor I will submit a claim to my insurance for this testing, if I have insurance. GeneDx will send an invoice to the patient listed above.		
Authorized Patient/Guardian Signature				
<input type="radio"/> INSTITUTIONAL BILL	GeneDx Account #		Place Sticker/Stamp Here	
Hospital/Lab Name				

First Name	Last Name	Date of Birth
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CLINICAL INFORMATION (DETAILED MEDICAL RECORDS MUST BE ATTACHED)

Diagnosis:
Dysmorphic features:
Other medical problems:
Suspected syndrome(s):
Previous cytogenetic or copy number variant test results (attach copy):
Clinical and family history:

<p>Pre/Perinatal History</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cystic hygroma <input type="checkbox"/> Diaphragmatic hernia <input type="checkbox"/> Encephalocele <input type="checkbox"/> Growth delay <input type="checkbox"/> Increased nuchal translucency <input type="checkbox"/> Intrauterine growth retardation <input type="checkbox"/> Neural tube defect <input type="checkbox"/> Omphalocele <p>Structural Brain Abnormalities</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormality of the corpus callosum <input type="checkbox"/> Holoprosencephaly <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Lissencephaly <input type="checkbox"/> Pachygyria <p>Developmental/Behavioral Findings</p> <ul style="list-style-type: none"> <input type="checkbox"/> Attention deficit hyperactivity disorder <input type="checkbox"/> Autistic behavior <input type="checkbox"/> Behavioral abnormality <input type="checkbox"/> Delayed fine motor development <input type="checkbox"/> Delayed gross motor development <input type="checkbox"/> Delayed speech & language development <input type="checkbox"/> Developmental regression <input type="checkbox"/> Gait disturbance <input type="checkbox"/> Global developmental delay <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Intellectual disability <input type="checkbox"/> OCD <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Specific learning disability <p>Neurological Findings</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormality of nervous system <input type="checkbox"/> Anosmia, congenital <input type="checkbox"/> Ataxia <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Encephalopathy <input type="checkbox"/> Epileptic encephalopathy <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Seizures <input type="checkbox"/> Spasticity 	<p>Craniofacial/Dysmorphism</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal facial shape (dysmorphic features) <input type="checkbox"/> Brachycephaly <input type="checkbox"/> Cleft lip <input type="checkbox"/> Cleft palate <input type="checkbox"/> Craniosynostosis <input type="checkbox"/> External ear malformation <input type="checkbox"/> Macrocephaly <input type="checkbox"/> Microcephaly <p>Eye Defects/ Vision</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormality of vision <input type="checkbox"/> Aniridia <input type="checkbox"/> Coloboma <input type="checkbox"/> Esotropia <input type="checkbox"/> Microphthalmia <input type="checkbox"/> Retinitis pigmentosa <p>Hearing Impairment</p> <ul style="list-style-type: none"> <input type="checkbox"/> Conductive hearing impairment/bilateral <input type="checkbox"/> Sensorineural hearing impairment/bilateral <p>Cardiac Findings</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal heart morphology <input type="checkbox"/> Atrial septal defect <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Coarctation of aorta <input type="checkbox"/> Tetralogy of Fallot <input type="checkbox"/> Ventricular septal defect <p>Gastrointestinal Findings</p> <ul style="list-style-type: none"> <input type="checkbox"/> Aganglionic megacolon <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Tracheoesophageal fistula <p>Musculoskeletal Findings</p> <ul style="list-style-type: none"> <input type="checkbox"/> Clinodactyly <input type="checkbox"/> Craniosynostosis <input type="checkbox"/> Hemihypertrophy <input type="checkbox"/> Hypertonia <input type="checkbox"/> Hypotonia <input type="checkbox"/> Pectus excavatum <input type="checkbox"/> Polydactyly <input type="checkbox"/> Scoliosis <input type="checkbox"/> Short stature <input type="checkbox"/> Syndactyly <input type="checkbox"/> Talipes equinovarus <input type="checkbox"/> Tall stature 	<p>Skin/Hair Findings</p> <ul style="list-style-type: none"> <input type="checkbox"/> Café-au-lait macules <input type="checkbox"/> Cutis laxa <input type="checkbox"/> Hyperpigmentation of the skin <input type="checkbox"/> Hypopigmentation of the skin <input type="checkbox"/> Ichthyosis <input type="checkbox"/> Sparse hair <p>Genitourinary Findings</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ambiguous genitalia <input type="checkbox"/> Cryptorchidism <input type="checkbox"/> Horseshoe kidney <input type="checkbox"/> Hydronephrosis <input type="checkbox"/> Hypospadias <input type="checkbox"/> Polycystic kidney disease <p>Metabolic Issues/Mito (Attach relevant lab reports/values)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Elevated CPK: _____ <p>Endocrine Findings</p> <ul style="list-style-type: none"> <input type="checkbox"/> Delayed puberty
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CYTOGENOMICS TEST REQUISITION FORM



First Name	Last Name	Date of Birth
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FAMILY HISTORY

No Known Family History
 Pedigree Attached
 Adopted

Relationship	Maternal	Paternal	Relevant History	Age at Dx
1	<input type="radio"/>	<input type="radio"/>		
2	<input type="radio"/>	<input type="radio"/>		
3	<input type="radio"/>	<input type="radio"/>		

PREVIOUS GENETIC TESTING

Personal or family history of genetic testing No Yes (If yes, please complete all fields below)

Relation to patient (self, sibling, etc.), Genetic Test(s) and Result (e.g. positive, negative, etc.). If relative was tested at GeneDx, please also provide their accession #: _____

If patient or relative(s) were found to have a positive or VUS result on prior testing, please provide details below. Indicate any Variants of Interest[‡] via the checkbox below.

Relation (self, sibling, etc.)	Gene	Transcript #	c./p. (SNV) or exon # (CNV)	Build, coordinates (CNV)	Variant of Interest? [‡]
1					<input type="checkbox"/>
2					<input type="checkbox"/>
3					<input type="checkbox"/>

Required for sequence variants: gene, c./p., transcript #
Required for CNVs: gene, transcript #, exon # OR build, coordinates

Abnormal karyotype, FISH, or other results: _____

[‡] For certain tests, GeneDx **may** be able to specifically comment upon the presence or absence of previously identified variant(s) of interest in the report. Complete variant information must be provided in the table above at the time the test order is placed. If you do not complete the table above and check off that a previously identified variant is a variant of interest, it will not be possible to comment upon the presence or absence of the variant in the report retrospectively. This service is not applicable to targeted variant testing.

TARGETED VARIANT TESTING

Individual to be tested: Affected/Symptomatic Unaffected/Asymptomatic

Known Familial Variant(s) in a Nuclear Gene
 Confirmation of Variant Identified in Research Lab
 Targeted Mosaic Variant Testing
 Known Familial Copy Number Variant(s)
 Known mtDNA Variant(s) Testing
 (Insurance Billing NOT Accepted; Patient Bill or Institutional Bill MUST be selected on page 1)

Proband Name	Relationship to Proband	Proband GeneDx Accession #
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Non-GeneDx Test: Family member test report included (recommended if previous test was performed at another lab)
 Positive control included/will be sent - **Positive control is recommended if previous test was performed at another lab.**
 Positive control not available (caveat language will be included on a negative report)

VARIANT INFORMATION (please fill out the below information if family member report is not included) Number of Variants: _____

Gene	Coding DNA (c./m.)	Amino Acid (p.)	Transcript (NM#)
Gene	Coding DNA (c./m.)	Amino Acid (p.)	Transcript (NM#)

COPY NUMBER VARIANT Number of Variants: _____

Gene(s)	Exon #	Coordinates	Genome Build
Gene(s)	Exon #	Coordinates	Genome Build

CYTOGENOMICS TEST REQUISITION FORM



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TEST MENU

TEST CODE	TEST NAME
<input type="checkbox"/> 910	Chromosomal Microarray (MicroarrayDx)
<input type="checkbox"/> J542	FISH Follow-up after Testing at GeneDx Please specify chromosomal region(s): 1: _____ 2: _____

PARENTS FOR MICROARRAYDX TESTING (Optional)

NO SEPARATE REPORT, ADDITIONAL SAMPLE(S) MUST BE RECEIVED PRIOR TO COMPLETION OF PROBAND'S MICROARRAYDX TEST

725	MicroarrayDx Parent Testing			
Biological Mother	First Name	Last Name	DOB	<input type="radio"/> Asymptomatic <input type="radio"/> Symptomatic <input type="radio"/> At GeneDx (Accession #: _____) <input type="radio"/> Not available <input type="radio"/> To be sent later
	First Name	Last Name	DOB	<input type="radio"/> Asymptomatic <input type="radio"/> Symptomatic <input type="radio"/> At GeneDx (Accession #: _____) <input type="radio"/> Not available <input type="radio"/> To be sent later
	First Name	Last Name	DOB	<input type="radio"/> Asymptomatic <input type="radio"/> Symptomatic <input type="radio"/> At GeneDx (Accession #: _____) <input type="radio"/> Not available <input type="radio"/> To be sent later

DID YOU REMEMBER TO...?

- Label specimen tube appropriately with TWO identifiers
- Get a signature for medical necessity and patient consent

GeneDx tests are frequently updated and improved based upon the most recent scientific evidence. The test codes, genes, and gene quantities listed on this test requisition are subject to change by GeneDx at any time. The most current test menu, list of genes, and technical limitations included for a specific test panel may be found on our website, genedx.com. Please note that GeneDx reserves the right to modify and upgrade any ordered panel to the version currently listed on our website.

First Name	Last Name	Date of Birth
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For the purposes of this consent, "I", "my", and "your" will refer to me or to my child, including my unborn child, if my child is the person for whom the healthcare provider has ordered testing.

PURPOSE OF THIS TEST

The purpose of this test is (a) to see if I may have a genetic variant or chromosome rearrangement causing a genetic disorder; or (b) to evaluate the chance that I will develop or pass on a genetic disorder in the future. If I already know the specific gene variant(s) or chromosome rearrangement that causes the genetic disorder in my family, I agree to inform the laboratory of this information.

WHAT TYPE OF TEST RESULTS CAN I EXPECT FROM GENETIC TESTING?

- Positive:** A change in your DNA was found, which is very likely the cause of your features/symptoms. This is the most straightforward test result, which can be used as the basis to test other family members to determine their chances of having either the disease or a child with the disease.
- Negative:** No variants were found to explain your symptoms. This does not mean that you do not have a genetic condition. It is still possible that there is a genetic variant not found by the test that was ordered. Your healthcare provider or genetic counselor may discuss more testing either now or in the future.
- Variant of Uncertain Significance (VUS):** A change in a gene was found. However, we are not sure whether this variant is the cause of your symptoms/features. More information is needed. We may suggest testing other family members to help figure out the meaning of the test result.
- Unexpected Results:** In rare instances, this test may reveal an important genetic change that is not directly related to the reason for ordering this test. For example, this test may find you are at risk for another genetic condition I am not aware of or it may indicate differences in the number or rearrangement of sex chromosomes. We may disclose this information to the ordering healthcare provider if it likely affects medical care.

Because medical and scientific knowledge is constantly changing, new information that becomes available may supplement the information GeneDx used to interpret my results. Healthcare providers can contact GeneDx at any time to discuss the classification of an identified variant.

WHAT IS TRIO/DUO-BASED GENETIC TESTING?

For some genetic tests, including samples from the biological parents and/or other biological relatives along with the patient's sample can help with the interpretation of the test results. These tests are often referred to as "trio tests" since they typically include samples from the patient and both parents.

Samples from relatives should be submitted with the patient's sample. Clinical information must be provided for the patient and any relative who submits a sample.

I understand that GeneDx will use the relative sample(s) when needed for the interpretation of my test results and that my test report may include clinical and genetic information about a relative when it is relevant to the interpretation of the test results. I further understand that relatives will not receive an independent analysis of data nor a separate report.

RISKS AND LIMITATIONS OF GENETIC TESTING

- In some cases, testing may not identify a genetic variant even though one exists. This may be due to limitations in current medical knowledge or testing technology.
- Accurate interpretation of test results may require knowing the true biological relationships in a family. I understand that if I fail to accurately state the biological relationships in my family, it could lead to incorrect interpretation of the test results, incorrect diagnoses, and/or inconclusive test results. If genetic testing reveals that the true biological relationships in a family are not as I reported them, including non-paternity (the reported father is not the biological father) and consanguinity (the parents are related by blood), I agree to have these findings reported to the healthcare provider who ordered the test.
- Although genetic testing is highly accurate, inaccurate results may occur. These reasons include, but are not limited to mislabeled samples, inaccurate reporting of clinical/medical information, rare technical errors, or other reasons.
- I understand that this test may not detect all of the long-term medical risks that I might experience. The result of this test does not guarantee my health and that additional diagnostic tests may still need to be done.
- I agree to provide an additional sample if the initial sample is not adequate.

PATIENT CONFIDENTIALITY AND GENETIC COUNSELING

It is recommended that I receive genetic counseling before and after having this genetic test. I can find a genetic counselor in my area at www.nsgc.org. Further testing or additional consultations with a healthcare provider may be necessary.

To maintain confidentiality, test results will only be released to the referring healthcare provider, the ordering laboratory, to me, to other healthcare providers involved in my care, diagnosis and treatment, or to others with my consent or as permitted or required by law. Federal laws prohibit unauthorized disclosure of this information. More information can be found at: www.genome.gov/10002077

INTERNATIONAL SAMPLES

If I reside outside the United States, I attest that by providing a sample for testing, I am not knowingly violating any export ban or other legal restriction in the country of my residence.

SAMPLE RETENTION

After testing is complete, my sample may be de-identified and be used for test development and improvement, internal validation, quality assurance, and training purposes. GeneDx will not return DNA samples to you or to referring healthcare providers, unless specific prior arrangements have been made.

I understand that samples from residents of New York State will not be included in the de-identified research studies described in this authorization and GeneDx will not retain them for more than 60 days after test completion, unless specifically authorized by my selection. The authorization is optional, and testing will be unaffected if I do not check the box for the New York authorization language. GeneDx will not perform any tests on the biological sample other than those specifically authorized.

DATABASE PARTICIPATION

De-identified health history and genetic information can help healthcare providers and scientists understand how genes affect human health. Sharing this deidentified information helps healthcare providers to provide better care for their patients and researchers to make new discoveries. GeneDx shares this type of information with healthcare providers, scientists, and healthcare databases. GeneDx will not share any personally identifying information and will replace the identifying information with a unique code not derived from any personally identifying information. Even with a unique code, there is a risk that I could be identified based on the genetic and health information that is shared. GeneDx believes that this is unlikely, though the risk is greater if I have already shared my genetic or health information with public resources, such as genealogy websites.

First Name	Last Name	Date of Birth
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EXOME/GENOME SEQUENCING SECONDARY FINDINGS

- Applicable only for full exome sequencing and genome sequencing tests
- Does not pertain to *Xpanded*[®] or *Slice* tests

As many different genes and conditions are analyzed in an exome or genome sequencing test, these tests may reveal some findings not directly related to the reason for ordering the test. Such findings are called "incidental" or "secondary" and can provide information that was not anticipated.

Secondary findings are variants, identified by an exome or genome sequencing test, in genes that are unrelated to the individual's reported clinical features.

The American College of Medical Genetics and Genomics (ACMG) has recommended that secondary findings identified in a specific subset of medically actionable genes associated with various inherited disorders be reported for all probands undergoing exome or genome sequencing. Please refer to the latest version of the ACMG recommendations for reporting of secondary findings in clinical exome and genome sequencing for complete details of the genes and associated genetic disorders. Reportable secondary findings will be confirmed by an alternate test method when needed.

WHAT WILL BE REPORTED FOR THE PATIENT?

All pathogenic and likely pathogenic variants associated with specific genotypes identified in the genes (for which a minimum of 10X coverage was achieved by exome sequencing or a minimum of 15X coverage was achieved by genome sequencing), as recommended by the ACMG.

WHAT WILL BE REPORTED FOR RELATIVES?

The presence or absence of any secondary finding(s) reported for the proband will be provided for all relatives analyzed by an exome or genome sequencing test.

LIMITATIONS

Pathogenic and/or likely pathogenic variants may be present in a portion of the gene not covered by this test and therefore are not reported. The absence of reportable secondary findings for any particular gene does not mean there are no pathogenic and/or likely pathogenic variants in that gene. Pathogenic variants and/or likely pathogenic variants that may be present in a relative, but are not present in the proband, will not be identified nor reported. Only changes at the sequence level will be reported in the secondary findings report. Larger deletions/duplications, abnormal methylation, triplet repeat or other expansion variants, or other variants not routinely identified by clinical exome and genome sequencing will not be reported.

FINANCIAL AGREEMENT AND GUARANTEE

For insurance billing, I understand and authorize GeneDx to bill my health insurance plan on my behalf, to release any information required for billing, and to be my designated representative for purposes of appealing any denial of benefits. I irrevocably assign to and direct that payment be made directly to GeneDx.

I understand that my out-of-pocket costs may be different than the estimated amount indicated to me by GeneDx as part of a benefit investigation. I agree to be financially responsible for any and all amounts as indicated on the explanation of benefits issued by my health insurance plan. If my insurance provider sends a payment directly to me for services performed by GeneDx on my behalf, I agree to endorse the insurance check and forward it to GeneDx within 30 days of receipt as payment towards GeneDx's claim for services rendered.

If I do not have health insurance, I agree to pay for the full cost of the genetic testing that was ordered by my healthcare provider and billed to me by GeneDx. I further understand and agree that, if I fail to make payment for genetic testing, in accordance with the payment policies of GeneDx, my account may be turned over to an external collection agency for non-payment. I agree to pay any associated collection costs, including attorney fees. By my signature on the GeneDx Test Requisition Form or at the bottom of this form, I accept full and complete financial responsibility for all genetic testing ordered by my healthcare provider.

MEDICARE

A completed Advance Beneficiary Notice (ABN) is required for Medicare patients, when applicable. Please visit our website, www.genedx.com/billing for more information.