HIBM Research Group
Non-profit molecular laboratory

Tel: (818) 789-1033
http://www.hibm.org/hrg

Laboratory Director: Marvin Pietruszka, MD, JD
Clinical Consultant: Daniel Darvish, MD
Consult Email: ddarvish@hibm.org

REQUISITION FORM – GENETIC ANALYSIS

IMPORTANT BILLING & SHIPPING INFORMATION: Before sending specimens, please fax back the completed billing information (page 2), and contact us for pre-authorization procedures. Samples received without billing pre-authorization cannot be processed. Ship specimens to HIBM Research Group, 18341 Sherman Way, #201A, Reseda, CA 91335.

PATIENT INFORMATION	REPORTING INFORMATION
Name (Last, First, MI): ______________________	Physician: ______________________
Birthdate (MM/DD/YYYY): ____ / ____ / ________	Institution: ______________________
Gender: ☐ Male ☐ Female ☐ Unknown	Address: ______________________
Hospital/Clinic Patient ID: ______________________	______________________
Hospital/Clinic Specimen ID: ______________________	City, State, Zip: ______________________
Ethnic Background (May check more than one): ☐Hispanic ☐Jewish ☐Asian ☐Middle-East ☐Americas ☐Europe ☐Africa ☐Australia	Phone: (_____) ____________ Fax: (_____) ____________ Additional reports to (e.g. Genetic Counselor):
Country of Origin: ______________________	Name: ______________________ Fax: (_____) ____________
Ethnic Background: ______________________	Name: ______________________ Fax: (_____) ____________

SPECIMEN INFORMATION - Please complete one form per specimen

Date Collected: ____ / ____ / ________ Time: _____ : _____ AM/PM. Collected by: ______________________

Specimen Type: ☐ Buccal ☐ Blood ☐ Mouthwash ☐ Other: ______________________

Specimen may be submitted as whole blood, buccal epithelial cells, or mouthwash. Transport at room temperature. Whole blood: Collect in either EDTA (lavender top) or ACD (yellow top) Vacutainer tubes. Submit at least 5 ml. Do not use whole blood from patients who have been recipients of a bone marrow transplant or whole blood products in the past 6 months; use buccal epithelial cells instead. Buccal epithelial: Obtain by rubbing standard cotton swabs or cyto-brush inside the cheeks (buccal). Submit at least 4 swabs or brushes. Mouth wash: Follow instructions enclosed in the mouthwash kit. Contact us for further information as needed.

Indication For Testing: ______________________

Test Menu (Gene Symbol) - Please check the tests requested

Muscle Diseases

HIBM, DMRV, IBM2 (GNE)
☐ Carrier Testing, Middle-East Founder, p.M712T
☐ GNE Sequence, Entire Coding Region

LGMD-2A (CAPN3)
☐ CAPN3 Sequence, Entire Coding Region

LGMD-2I or CMD-1C (FKRP)
☐ Carrier Testing, p.L276I
☐ FKRP Sequence, Exon 4

LGMD-1B (LMNA)
☐ LMNA Sequence, Entire Coding Region. Mutations in LMNA also associated with Emery-Dreifus Muscular Dystrophy, Dilated Cardiomyopathy, Lipodystrophy, Charcot-Marie-Tooth 2B1, Hutchinson-Gilford Progeria, Restrictive Dermopathy.

Other Tests

Cystic Fibrosis (CFTR)
☐ Carrier Testing, ACMG/ACOG recommended mutation panel
☐ CFTR Sequence, Entire Coding Region

Others
☐ MTHFR Thermolabile Variant, p.A222V, 677C>T
☐ Factor V Leiden Variant, p.R506Q, 1691G>A
☐ TB Test, Tuberculosis T-cell based IGRA, T-SPOT® Please contact the laboratory at time of blood draw. Must be received within 24 hours after blood draw. Use Lithium Heparin tube (BD Cat# 367886, green-top).

Custom Order Test Requests: ------------------------------

DNA Identity
☐ DNA Identity. 16 microsatellite markers, including the 13 CODIS markers and Amelogenin for gender determination. For paternity, immigration requirements, or court admissible forensic identity testing, please contact us before submitting specimen to obtain additional chain of custody form.

I am the referring clinician and I have reviewed the required patient informed consent information. I accept responsibility for pre- and post-test genetic counseling.

Ordering Clinician: ______________________ Signature: ______________________ Date: ______________

For Lab Use: Received by: ______________ Date/Time Received: ______________ Version 2009-06
Specimen Type Received: ______________ Requisition Complete? Yes / No
Notes:

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BILLING INFORMATION & PRE-AUTHORIZATION

PLEASE INDICATE ONE OF THE THREE FOLLOWING BILLING OPTIONS. The Self-Pay option should include payment with sample. We require and provide insurance pre-verification service as needed. Please fax back this information prior to sending patient sample for testing. If the billing information section is incomplete, we are not able to process the specimen.

PATIENT INFORMATION: Name (Last, First, MI): ______________________________

Address: ______________________________ City, State, Zip: ______________________________

Phone #: (____) ______________________________ Email: ______________________________

PAYMENT OPTIONS:

1. **Self-Pay:** Check or Money Order payment must accompany sample. Otherwise, below information should be completed.
   Credit Card (Please check/circle one): ☐ AMEX ☐ Discover ☐ MC ☐ VISA
   Valid Card #: ______________________________ Exp date (mm/yy): ___ /___ CVC Code: __________
   Address where CC statements are sent: ______________________________
   City, State, Zip: ______________________________
   Cardholder printed name: ______________________________ Cardholder signature: ______________________________
   E-mail (required): ______________________________

2. **Payment by referring institution or healthcare professional:**
   Institution Name: ______________________________
   Billing Address: ______________________________
   City, State, Zip: ______________________________
   Financial Contact: ______________________________
   Phone #: (_____) ______________________________ Fax #: (_____) ______________________________
   E-mail (required): ______________________________

3. **Insurance**: Pre-verification by Medical Genetics Lab is required. Please complete and fax this form prior to sample receipt. Patients are responsible for non-covered services, deductibles, and balances.
   Please provide diagnostic code(s) as appropriate. ICD-9 CODE: ______________________________
   Name: ______________________________ Birth Date (mm/dd/yyyy): ____/____/_________
   Insured SS or ID #: ______________________________ Gender (check one): ☐ M ☐ F
   Authorization: ______________________________
   Relationship to Patient: ______________________________
   Insurance Name: ______________________________
   Employer: ______________________________ Group #: ______________________________
   Insurance Address: ______________________________
   Insurance City, State, Zip: ______________________________
   Insurance Phone #: (____) ______________________________

I authorize HRG to furnish any medical information requested on myself, or my covered dependents. For services rendered, I transfer and assign any benefits of insurance to HRG. I understand I am responsible for any co-pay, deductible, or non-covered service amounts. I understand that I am responsible for payment if my health plan does not fully reimburse my medical services due to lack of authorization or medical necessity.

Signature: ______________________________ Date (mm/dd/yyyy): _____/______/____________

Print Name: ______________________________

For Lab Use: Received by: ______________________ Date/Time Received: _________________ Version 2007-08
Pre-Authorization: ______________________________ Notes: ______________________________

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Informed Consent for Genetic Testing

Patient Name: ____ Birth Date: ____/____/_______ Sex: [ ] M [ ] F

I request the following test(s) ordered: ____.

The intended purpose is: [ ] Screening [ ] Diagnosis [ ] Carrier Status [ ] Other: ______________________________

The Department of Health and Human Services defines genetic testing as "…an analysis performed on human DNA, RNA, genes and/or chromosomes to detect heritable or acquired genotypes, phenotypes, or karyotypes that cause or are likely to cause a specific disease or condition. A genetic test is also the analysis of human proteins and certain metabolites, which are predominantly used to detect heritable or acquired genotypes, mutations, or phenotypes."

The result of genetic testing may irreversibly affect your future. Before testing, you should be well informed about the possible test results and how it may affect your life. The implications that may arise from the test results may involve both medical and psychosocial issues. Result of genetic tests may lead to unwanted discrimination (insurance or work-related). Genetic testing performed by the laboratory is near 100% accurate. However, because of technological and scientific limitations, some genetic testing may not always give a definite answer as desired. Usually, genetic test results may: (a) diagnose whether or not you have, or may be at risk for, a genetically inherited condition, (b) indicate whether or not you are a carrier for this condition, (c) predict another family member has or is at risk for developing this condition, (d) predict another family member is a carrier of this condition, (e) be indeterminate due to technical limitations or familial genetic patterns, or (f) reveal non-paternity when both father and child are tested.

This genetic test is specific only for the tests named above. It will not detect all mutations possible within this gene, nor detect mutations in other genes. Your sample, or your children's or fetus' samples, may be used for validation of future tests and/or educational purposes after personal identifiers are removed (irreversibly de-identified). For such use, the sample(s) may be stored indefinitely. If any de-identified sample test result shows that the health of the donor (the person from whom sample was obtained) may be at significant risk by a potentially serious disease, an informative letter will be mailed to everyone whose sample may have been included in the batch of de-identified samples. Refusal to permit the use of your sample for such future test validation and/or educational purposes will not affect the results of the tests ordered above. You can withdraw your consent at any time by contacting the laboratory.

Please be sure to provide your physician with accurate reports of family medical history and biological relationships. Test interpretation may depend on accurate family history information. Also, it is the patient's responsibility alone to inform other family members of possible genetic risks they may have. In some cases, genetic testing may reveal previously unrecognized biological relationships, such as non-paternity or a genetic condition in another family member. Genetic analysis is a fee-for-service test. You will be responsible for payment after the testing has begun, even if you decide not to receive the results.

I request and authorize the use of my sample for genetic testing. My signature below constitutes my acknowledgment that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified clinician. I authorize the release of my test result to the clinician listed below.

_______________________________________ ____

Print patient's name Print Name of Legal Guardian (If patient is below 18 years of age)

____________________________ ____ _____________________

Signature Relationship to patient Date

Clinician (Physician or other Health Professional)

I, the referring clinician, have reviewed this form with the patient and/or patient's parent or guardian. I have explained genetic testing and its limitations to the patient or legal guardian and answered all questions.

____ ____

Print clinician's name, relevant degree Institution, City, State Zip

_____________________________ ___________ ____

Signature Date Phone / Fax / Email

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Location
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CAP: LAP7179300
CLIA: 05D-0992853
LFS: CLF328498

T-SPOT.TB®

LABORATORY REQUEST FORM

T-SPOT®.TB is an in vitro diagnostic test for the detection of T-cells that respond to stimulation by Mycobacterium tuberculosis antigens ESAT-6 and CFP-10 by capturing interferon gamma (IFN-γ) in the vicinity of T cells in human whole blood. It is considered to be generally more sensitive and more specific than TB skin testing.

COLLECTION DATE/TIME

____

____

- Samples are accepted within 30 hours of being drawn, Mon – Thu, 8:30AM to 2:00PM.
- Submit 6mL tube, additive Lithium Heparin (BD Cat# 367886, green-top)
- Children up to 2 years old: one 3mL pediatric tube Heparin (Li)
- For patients with low lymphocyte count (Immune suppressed/immune deficient), please provide double the amount of blood
- Blood must be kept at room temperature during transport.
- Refrigerated or frozen samples will not be accepted.
- Please contact the lab at (818) 789-1033 when sending a sample.

REFERRING/ATTENDING PHYSICIAN

Name:__________________________________ Copy to: ____________________________

Phone/Fax: ______________________________ ______________________________

Address: _______________________________ ______________________________

PATIENT INFORMATION *****PLEASE ATTACH APPROPRIATE BILLING INFORMATION**

Name:____ DOB:____________________

Address: _______________________________________ SSN: ____________________

City: ____________________ State: ____ Zip: __________ Phone: ____________________

Medical Records / Reference #: ____

CLINICAL INFORMATION

☐ Employment Screening ☐ Health Care Worker ☐ Pregnant ☐ Nursing Home Transfer

☐ Immune suppressed ☐ Immune Deficient ☐ HIV/AIDS ☐ BCG Immunized

☐ Foreign born (country) ____________________ ☐ Foreign travel (country) ____________________

Exposure contact (Name):____

TST+/- and size (mm) __________ CXR+/- and description __________________________________

Previous Treatment for TB (year, duration) ____

Other TB risk information ____

PLEASE NOTE: Testing must be done on fresh blood and samples <u>must be</u> received for processing in the testing laboratory within 30 hours. Blood draw should be scheduled on Sunday afternoon to Thursday morning and delivered to the lab by Thursday at 2:00pm.

After hours or in case of emergency, please contact Dr. Yadira Valles-Ayoub, mobile (818) 274-1843.

Version 2009-07