



GENERAL GENETIC TESTING REQUISITION FORM

PATIENT INFORMATION

Last Name First Name MI Gender Male Female Unknown
DOB (MM/DD/YY) MRN Phone number Email
Address City State Zip Code

ORDERING PHYSICIAN Mark If Preferred Contact

Name Institution
NPI# Specialty Address
Phone Fax
Email City State Zip Code

GENETIC COUNSELOR Mark If Preferred Contact

Name Phone Email/Fax

ADDITIONAL RESULTS RECIPIENTS

Name Phone Email/Fax
Name Phone Email/Fax

TEST SUBMISSION CHECKLIST

- Patient and Sample Information
Test Requested
Billing Information
Clinical Information Form
Signed Informed Consent
ICD-10 Codes
Sample(s) with Two (2) Identifiers
Medical Records - Attach
Client Registration Form (new clients only)

STATEMENT OF MEDICAL NECESSITY

For Providers from NEW YORK STATE, a signature below is required.

By sending this sample, I acknowledge that:

- I am a healthcare provider authorized to order genetic testing in the location that I practice;
This test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom, syndrome, or disorder and that these results will be used in the medical management and treatment decisions for this patient;
I am responsible for returning the results of genetic testing to my patient and/or legal guardian and for ensuring that my patient receives appropriate genetic counseling to understand the implications of his/her test;
The patient/legal guardian has been provided information regarding the risks/benefits and limitations of the test(s) ordered and the patient/legal guardian has given consent for the ordered test(s) to be performed;
I have obtained all signatures as necessary under the laws of my state;
Upon request I am able to produce the consent form signed by the patient/guardian.

PROVIDER SIGNATURE DATE (MM/DD/YY)

SAMPLE INFORMATION

Patient Not all sample types are acceptable for all tests. See the Specimen Requirements page on our website for more detailed information.

Specimen Type Whole Blood DNA Bone Marrow
Saliva Blood Spot Card

Collection: Date Time AM/PM (circle one)

Check this box if the patient has ever had a bone marrow transplant.

PROBAND INFORMATION FOR PARENTAL/RELATED CONFIRMATION TESTING:

If parental or related confirmation testing is being requested, please include all of the following information on the proband if testing for the proband was completed at Claritas Genomics.

Name
DOB (MM/DD/YY)
MRN
Test Name
Claritas Accession #



Test Requested

Sanger Sequencing-Complete Gene	Test Code		
<input type="checkbox"/> ALX3	S0801	<input type="checkbox"/> PTEN	S0508
<input type="checkbox"/> ARX	S0962	<input type="checkbox"/> PTPN11	S0204
<input type="checkbox"/> CDKL5	S0231	<input type="checkbox"/> RAF1	S0690
<input type="checkbox"/> CHD7	S0368	<input type="checkbox"/> ROBO3	S0202
<input type="checkbox"/> CHN1	S0821	<input type="checkbox"/> RPL11	S0055
<input type="checkbox"/> COL1A1	S0311	<input type="checkbox"/> RPL5	S0510
<input type="checkbox"/> COL1A2	S0640	<input type="checkbox"/> RPS19	S0804
<input type="checkbox"/> CYP24A1	S0011	<input type="checkbox"/> RPS24	S0095
<input type="checkbox"/> DCX	S0846	<input type="checkbox"/> SALL4	S0101
<input type="checkbox"/> DHCR7	S0752	<input type="checkbox"/> SBDS	S0182
<input type="checkbox"/> ELANE	S0524	<input type="checkbox"/> SCN1B	S0093
<input type="checkbox"/> ERCC6	S0161	<input type="checkbox"/> SLC26A3	S0372
<input type="checkbox"/> ERCC8	S0948	<input type="checkbox"/> SLC26A4	S0587
<input type="checkbox"/> F13A1	S0218	<input type="checkbox"/> SLC9A6	S0968
<input type="checkbox"/> F13B	S0961	<input type="checkbox"/> SMPD1	S0401
<input type="checkbox"/> FANCA	S0715	<input type="checkbox"/> SOS1	S0584
<input type="checkbox"/> FANCC	S0348	<input type="checkbox"/> SPRED1	S0749
<input type="checkbox"/> FANCG	S0075	<input type="checkbox"/> SYNGAP1	S0171
<input type="checkbox"/> FGFR2	S0845	<input type="checkbox"/> TBX22	S0418
<input type="checkbox"/> FLNA	S0013	<input type="checkbox"/> TCF4	S0902
<input type="checkbox"/> FOXG1	S0823	<input type="checkbox"/> TMPRSS6	S0574
<input type="checkbox"/> GAA	S0249	<input type="checkbox"/> TUBB3	S0983
<input type="checkbox"/> GABRG2	S0531	<input type="checkbox"/> TWIST1	S0313
<input type="checkbox"/> GALT	S0903	<input type="checkbox"/> TYR	S0896
<input type="checkbox"/> GATA1	S0740	<input type="checkbox"/> UBE3A	S0104
<input type="checkbox"/> GBA	S0613	<input type="checkbox"/> XPA	S0004
<input type="checkbox"/> GJB2 [Connexin 26]	S0908	<input type="checkbox"/> XPC	S0270
<input type="checkbox"/> GLA	S0128		
<input type="checkbox"/> GPR56	S0918		
<input type="checkbox"/> HAX1	S0864		
<input type="checkbox"/> HOXA1	S0390		
<input type="checkbox"/> IDUA	S0495		
<input type="checkbox"/> IRF6	S0074		
<input type="checkbox"/> JAG1	S0581		
<input type="checkbox"/> KRAS	S0713		
<input type="checkbox"/> MECP2	S0440		
<input type="checkbox"/> MSX1	S0900		
<input type="checkbox"/> NLGN3	S0483		
<input type="checkbox"/> NLGN4	S0050		
<input type="checkbox"/> NPHP1	S0339		
<input type="checkbox"/> NSD1	S0544		
<input type="checkbox"/> OCA2	S0212		
<input type="checkbox"/> PHOX2A	S0773		
Deletion/Duplication Analysis	Test Code		
<input type="checkbox"/> 1p36 Deletion/Duplication	C0822		
<input type="checkbox"/> 1q21 Deletion/Duplication	C0121		
<input type="checkbox"/> 15q13.2q13.3 Deletion/Duplication	C0387		
<input type="checkbox"/> 16p11.2 Deletion/Duplication	C0116		
<input type="checkbox"/> 17q12 Deletion/Duplication	C0109		
<input type="checkbox"/> 17q21 Deletion/Duplication	C0552		
<input type="checkbox"/> Angelman/ Prader-Willi Syndrome Methylation and Deletion/Duplication [15q11q13]	C0703		
<input type="checkbox"/> Cri du Chat Syndrome Deletion [5p-]	C0247		
<input type="checkbox"/> DCX Deletion/Duplication	C0593		
<input type="checkbox"/> DMD Deletion/Duplication	C0507		
<input type="checkbox"/> FLNA Deletion/Duplication	C0569		
<input type="checkbox"/> GALT Deletion/Duplication	C0046		



Test Requested continued

<input type="checkbox"/> GJB6 Deletion [Connexin 30]	T0852
<input type="checkbox"/> JAG1 Deletion/Duplication	C0711
<input type="checkbox"/> Langer-Giedion Syndrome Deletion [TRPS1, EXT1]	C0049
<input type="checkbox"/> MECP2 Deletion/Duplication	C0105
<input type="checkbox"/> Miller-Dieker Syndrome Deletion [17p13.3]	C0975
<input type="checkbox"/> NF1 Deletion/Duplication	C0582
<input type="checkbox"/> NF2 Deletion/Duplication	C0699
<input type="checkbox"/> NSD1 Deletion/Duplication	C0736
<input type="checkbox"/> PMP22 Deletion/Duplication	C0998
<input type="checkbox"/> PTEN Deletion/Duplication	C0466
<input type="checkbox"/> Rubinstein-Taybi Syndrome Deletion [16p13.3]	C0291
<input type="checkbox"/> Smith-Magenis Syndrome Deletion [17p11.2]	C0304
<input type="checkbox"/> SMN1 Exon 7 Deletion/Duplication	T0996
<input type="checkbox"/> SPRED1 Deletion/Duplication	C0905
<input type="checkbox"/> TCF4 Deletion/Duplication	C0265
<input type="checkbox"/> TWIST1 Deletion/Duplication	C0537
<input type="checkbox"/> Velocardiofacial/ DiGeorge Syndrome Deletion/Duplication [10p13-p14, 22q11.2]	C0207
<input type="checkbox"/> WAGR Syndrome Deletion [11p13]	C0108
<input type="checkbox"/> Williams Syndrome Deletion [7q11.2]	C0253
<input type="checkbox"/> Wolf-Hirschhorn Syndrome Deletion [4p-]	C0272

<input type="checkbox"/> Mitochondrial tRNA-Leu (MT-TL1) Variants	T0167
<input type="checkbox"/> Mitochondrial tRNA-Lys (MT-TK) Variants	T0014
<input type="checkbox"/> Mitochondrial tRNA-Ser (MT-TS1) Variants	T0419
<input type="checkbox"/> MTHFR Thermolabile Variant Analysis	T0027
<input type="checkbox"/> Muenke Syndrome Variant Analysis	T0285
<input type="checkbox"/> Pfeiffer syndrome FGFR1 Variant Analysis	T0810
<input type="checkbox"/> Prothrombin Variant Analysis	T0577

Other	Test Code
<input type="checkbox"/> ClariView Array (Microarray)	C0744
<input type="checkbox"/> FMR1 CCG Repeat Analysis (Fragile X Testing)	T0220
<input type="checkbox"/> OCA2 2.7 kb Deletion	T0363
<input type="checkbox"/> TPMT Haplotype Analysis	T0958
<input type="checkbox"/> UGT1A TA Repeat Analysis	T0958
<input type="checkbox"/> Y Chromosome Sequence Detection [SRY, TTTY11, DDX3Y]	T0043

Use our Exome-Based Testing Requisition form to order the Claritas Clinical Exome, our whole exome sequencing test, as well as our Region of Interest tests that focus on specific pediatric rare inherited diseases.

Targeted Variant Analysis	Test Code
CLIA Confirmation of Research Findings	Call to discuss
<input type="checkbox"/> Using Existing Primers	
<input type="checkbox"/> Using Custom-Designed Primers	
Gene name:	
Variant(s) in HGVS nomenclature:	
NM# used for variant analysis:	
Protocol used (examples: Sanger, forward primer sequence, reverse primer sequence, PCR material and condition):	
<input type="checkbox"/> Familial Targeted Variant Analysis	Call to discuss
Gene name:	
Variant(s):	
Name of proband:	
Proband MRN:	
Relationship to proband:	
<input type="checkbox"/> Achondroplasia/Hypochondroplasia Variant Analysis	S0884
<input type="checkbox"/> Apert Variant Analysis	T0106
<input type="checkbox"/> Crouzon Syndrome with Acanthosis Nigricans Variant Analysis	T0441
<input type="checkbox"/> Factor V Leiden Variant Analysis	T0423
<input type="checkbox"/> KIF21A Select Exon Sequencing	T0868
<input type="checkbox"/> Melnick-Needles Syndrome Select Exon Analysis	T0635
<input type="checkbox"/> Mitochondrial 12S rRNA (MT-RNR1) Variants	S0920



Clinical Information

PATIENT NAME: _____ DOB: _____

REQUIRED: ICD-10 CODE(S): _____

Provide Main Clinical Indication and Differential Diagnosis/Diagnoses: _____

COGNITIVE/DEVELOPMENTAL/BEHAVIORAL

- Global developmental delay
- Motor delay: Gross Fine
- Speech delay
- Intellectual disability
- Learning disability
- Developmental regression
- Autism spectrum disorders
- Psychiatric symptoms _____
- OTHER _____

GROWTH

- Stature: Short Tall
- Obesity Overgrowth
- Failure to thrive
- Hemihypertrophy _____
- OTHER _____

HEAD/BRAIN/FACE

- Micro- Macro-cephaly
- Abnormal head shape: _____ cephalo
- Craniosynostosis _____ suture(s)
- Brain abnormality: _____
- Micro- Pro- Retro-gnathia
- Cleft: Lip Palate
- Abnormality of Mouth _____
- Abnormality of Nose _____
- Abnormality of Eyes _____ Vision _____
- Hypo- Hyper-telorism
- Abnormality of Eyebrows _____ Synophrys
- Abnormality of Ears _____
- Hearing loss: Sensorineural Conductive
- Abnormality of Teeth _____
- Abnormality of Neck _____
- Facial asymmetry
- Facial: Palsy Paralysis Weakness
- OTHER _____

SKIN/HAIR

- Hyper- Hypo-pigmentation
- Café-au-lait spots
- Skin: Tags Tumors
- Ichthyosis
- Abnormal Nails _____
- Alopecia
- Abnormal Hair: Quantity Texture _____
- Abnormal Connective Tissue _____
- OTHER _____

PERINATAL HISTORY

- Prematurity _____ weeks
- IUGR
- Oligo- Poly-hydramnios
- Cystic hygroma/increased NT
- H/o recurrent pregnancy losses

CARDIOVASCULAR

- Conotruncal anomaly _____
- Atrial Ventricular septal defect
- Cardiomyopathy: DCM HCM LVNC
- Coarctation of aorta
- Hypoplastic left heart
- Arrhythmia/conduction defect
- OTHER _____

GASTROINTESTINAL

- Tracheoesophageal fistula
- Gastroschisis
- Omphalocele
- Hirschsprung disease
- Chronic diarrhea
- Constipation
- Recurrent vomiting
- Pyloric stenosis
- Gastroesophageal reflux
- Anal atresia
- Hepato- Spleno-megaly
- OTHER _____

GENITOURINARY

- Kidneys
 - Hydronephrosis
 - Malformation _____
 - Nephrotic syndrome
 - Tubulopathy
 - Agenesis
- Bladder _____
- Ambiguous genitalia
- Hypospadias
- Cryptorchidism
- OTHER _____

MUSCULAR/NEUROLOGICAL

- Seizures Type _____
- Tone: Hypotonia Hypertonia
- Spasticity
- Movement disorder
 - Ataxia
 - Chorea
 - Dystonia
- Muscle weakness: Proximal Distal
- Neurodegeneration
- Stroke
- Cranial nerve _____
- Sleep disturbance
- Headache/migraine
- Neural tube defect _____
- Diaphragmatic hernia
- Umbilical hernia
- OTHER _____

SKELETAL/LIMB

- Limb shortening Upper Lower Right Left
- Limb anomaly _____
- Thumb anomaly _____
- Polydactyly Pre- Post-
- Syn- Ectro- Arachno-dactyly
- Small Large Hands Feet
- Club foot Unilateral Bi-lateral
- Scoliosis Kyphosis Lordosis
- _____ Fracture(s)
- Wormian bones
- Vertebral anomaly _____
- Contractures
- OTHER _____

METABOLIC

- CPK abnormality
- Ketosis
- Amino Organic -acidemia -aciduria
- Specify _____
- OTHER _____

ENDOCRINE

- Diabetes: Type I Type II
- Hypo- Hyper-thyroidism
- Hypoparathyroidism
- Pheochromocytoma/paraganglioma
- OTHER _____

IMMUNOLOGIC

- Immunodeficiency _____
- OTHER _____

HEMATOLOGIC

- Anemia
- Neutro- Pancyto- Thrombocyto-penia
- Increased bleeding
- Thrombosis
- Transient abnormal myelopoiesis
- Juvenile myelomonocytic leukemia
- OTHER _____

MALIGNANCY

- Tumor type/Location _____
- Age of onset _____

PREVIOUS TESTING/RESULT

- Chromosomes: _____
- FISH: _____
- Array CGH: DEL _____ DUP _____
- Biochemical: _____
- Biopsy: _____
- Imaging: _____
- OTHER: _____

Attach previous results

FAMILY HISTORY (For complex family histories, attach additional pages): _____

ETHNICITY : _____ CONSANGUINITY: NO YES. IF YES, SPECIFY RELATIONSHIP: _____



Informed Consent Signatures

PATIENT NAME: _____ DOB: _____

TEST(S) ORDERED: _____

INFORMED CONSENT

More information on all policies may be found in the Informed Consent Guide.

By signing below, I, the **patient/guardian**, confirm the following:

- a) The risks, benefits, and limitations of the test have been described to me;
- b) I have had a chance to have my questions answered;
- c) I choose to have this test;
- d) No tests other than those authorized shall be performed on the sample.
- e) I agree to Claritas's policies on Specimen Retention and De-identified Scientific and Medical Research.
 - Check here if you do not wish to participate in any research studies.
- f) I agree that Claritas may contact me in the future for research opportunities, including treatment.
 - Check here if you do not want to be contacted in the future for research opportunities, including treatment.
- g) Authorization for samples sent by a provider from New York State:
 - My sample is being sent from a provider from New York State and I, the patient, give permission for Claritas Genomics to retain any remaining sample longer than 60 days after completion of testing and use my de-identified data for scientific and medical research purposes. Such authorization is optional and is not required for testing.

Patient signature, or guardian if patient is under 18

Date

When **parental samples** are sent for clinical genetic tests that are not "for the purpose of diagnosing or detecting an existing disease, illness, impairment, or disorder," [as per Massachusetts Ann. Laws ch. 111 section 70G (2000)] consent must be documented.

By signing below, the parent confirms the following:

- a) I understand the intent of testing a parent is to identify the presence or absence of genetic changes similar to that found in my child;
- b) I understand that the interpretation of my child's genetic testing result may change depending on whether or not the genetic change(s) is/are present in me. I understand that for this reason, Claritas Genomics will include my genetic test result in my child's report for the purpose of assisting with the interpretation of that test result;
- c) I have had a chance to have my questions answered;
- d) I choose to send my sample to Claritas Genomics where it may or may not be used depending on whether genetic changes were identified in my child;
- e) No tests other than those authorized shall be performed on my sample.
- f) I agree to Claritas's policies on Specimen Retention and De-identified Scientific and Medical Research.
 - Parent 1** (as signed below): Check here if you do not wish to participate in any research studies.
 - Parent 2** (as signed below): Check here if you do not wish to participate in any research studies.
- g) I agree that Claritas may contact me in the future for research opportunities, including treatment.
 - Parent 1** (as signed below): Check here if you do not want to be contacted in the future for research opportunities, including treatment.
 - Parent 2** (as signed below): Check here if you do not want to be contacted in the future for research opportunities, including treatment.
- h) Authorization for samples sent by a provider from New York State:

My sample is being sent from a provider from New York State and I, the patient, give permission for Claritas Genomics to retain any remaining sample longer than 60 days after completion of testing and use my de-identified data for scientific and medical research purposes. Such authorization is optional and is not required for testing.

 - Parent 1** (as signed below): Check here to authorize this statement.
 - Parent 2** (as signed below): Check here to authorize this statement.

Parent signature

Print Name

Relationship to Patient (i.e., Mother or Father)

Date

Parent signature

Print Name

Relationship to Patient (i.e., Mother or Father)

Date



Billing Information

PATIENT NAME: _____ DOB: _____

1. INSTITUTIONAL BILLING

Client Code _____ Enter the Client Code provided by Claritas Genomics' Client Service team. If you do not have a client code, complete the Client Registration Form, available at www.claritasgenomics.com or by contacting Client Services: clientservices@claritasgenomics.com or toll-free 855-373-9003. **Claritas will not begin testing until all information is complete.**

2. INSURANCE BILL

Client Code _____ Enter the Client Code provided by Claritas Genomics' Client Service team. If you do not have a client code, complete the Client Registration Form, available at our website or by contacting Client Services.

Claritas Genomics will directly bill third party insurances. Required Information:

- **A legible photocopy, front and back, of the insurance card**
- **A copy of the insurance authorization, if obtained**
- **Completed Insurance Billing information requested below**

Claritas Genomics will perform an insurance benefits investigation and/or prior authorization, when requested. Please see the insurance billing section on our website for additional information and requirements.

Claritas will not begin testing until all information is complete and obtained.

PRIMARY INSURANCE		SECONDARY INSURANCE	
Policyholder's Name		Policyholder's Name	
Policyholder's Date of Birth (MM/DD/YY)	Relationship to Patient	Policyholder's Date of Birth (MM/DD/YY)	Relationship to Patient
Insurance Carrier	Insurance Carrier Phone Number	Insurance Carrier	Insurance Carrier Phone Number
Policy Number		Policy Number	
Group Number	Auth Number	Group Number	Auth Number
Insurance Address	City/State/Zip	Insurance Address	City/State/Zip
Policyholder's Signature	Date	Policyholder's Signature	Date

Patient/Family Acknowledgment

I (The Insured) acknowledge that the information provided by me is true to the best of my knowledge. For billing my insurance company: I hereby authorize my insurance benefits to be paid directly to Claritas Genomics and authorize them to release medical information concerning my testing to my insurer to achieve payment. If applicable, I authorize Claritas Genomics to be my Designated Representative for purposes of appealing any denial of benefits to achieve payment. I understand that I am financially responsible for any amounts not covered by my insurer for this test. Claritas Genomics will bill patients/families for non-covered services, co-payments, deductibles, co-insurance, or balances as required by their insurer unless the patient meets certain financial criteria as defined in the Claritas Genomics Financial Assistance Program. I also understand that I am legally responsible for sending Claritas Genomics any money received directly from my health insurance company for performance of this test.

Insured's printed name _____ Signature _____ Date _____

Patient's/guardian's phone number, to be used to communicate benefits information _____

3. SELF-PAY

Complete the Credit Card Payment Form, available on our website or by calling our Client Services team toll-free at 855-373-9003.

4. FINANCIAL ASSISTANCE PROGRAM

Check to indicate that patient or family is experiencing economic hardships Check to indicate Provider is giving free medical care

Include a completed Claritas Patient Financial Assistance Application, which is available on our website or by contacting Client Services.

CLARITAS GENOMICS INC. | 99 Erie Street Cambridge, MA 02139 | e: clientservices@claritasgenomics.com | p: 617.553.5880 | p: 855.373.9003 | f: 617.553.5842

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