PerkinElmer For the Better | PerkinElmer GENOMICS

Single Gene and Panel Testing Requisition Form

Please complete every field and tick box clearly.

PATIENT INFORMATION

Patient's First Name | Middle Initial | Patient's Date of Birth (MM/ DD /YYYY)

Patient's Last Name | Patient ID/MR Number

Biological Sex: ○ Male ○ Female ○ Unknown
Gender Identity (if different from above): _____

Patient's Street Address

City / Town | State | Zip Code

Country | Patient's Preferred Phone

Patient's Email

Ethnicity (check all that apply):	○ African-American	○ Asian (China, Japan, Korea)
○ Caucasian/N. European/S. European	○ Finnish	○ French Canadian
○ Hispanic	○ Jewish - Ashkenazi	○ Jewish - Sephardic	○ Mediterranean
○ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)	○ Native American	○ E. Indian
○ Southeast Asian (Vietnam, Cambodia, Thailand)	○ South Asian (India, Pakistan)	
○ Other (specify) _____		

ORDERING PROVIDER

Provider's First and Last Name

PKIG Ordering Provider Account Number | NPI

Clinic/Hospital/Institution Name

Provider's Email | Provider's Phone

Provider's Street Address

City / Town | State | Zip Code

Country | Provider's Fax

SEND ADDITIONAL COPY OF RESULTS TO (If applicable)

Name

PKIG Ordering Provider Account Number | Phone Number

Email Address | Fax Number

PATIENT SAMPLE INFORMATION

SAMPLE TYPE:
○ Saliva Swab
○ Whole Blood
○ Dried Blood Spots
Other_____

Collection Date: MM/DD/YY

Was this sample collected in NY State: ○ yes ○ no

INDICATION FOR TESTING (Required)

ICD10 Code(s): _____
Clinical Diagnosis: _____
Age at Initial Presentation: _____

TEST MENU

AnyPanel™ Test

○ D3000 AnyPanel™ Test: Custom Panel
Please submit custom requested gene list for testing at apps.perkinelmergenomics.com/genelist, and include custom panel ID below

AnyGene™ Test

○ D3100 AnyGene™ Test: Single Gene Sequencing and Del/Dup Test
Please submit requested gene for testing at apps.perkinelmergenomics.com/genelist, and include custom gene ID below

PROVIDE GENE OR CUSTOM PANEL ID HERE:

○ Curated panel by clinical indication
Choose any of our multigene disease-specific next-generation sequencing panels (no reflex options). Clinical indications include neuromuscular, neurology, cardiology, hereditary cancer, and other categories such as hearing loss and ophthalmology. Log into ordering portal to select the correct panel at https://client.perkinelmergenomics.com/login/

TO ORDER ON PAPER:
Provide test code here: _____
Provide test name here: _____

Please note: STAT test codes are not billable to insurance.

PHYSICIAN CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate informed consent for the testing ordered, including a discussion of the benefits and limitations. I confirm that testing is medically necessary and that test results may impact medical management for the patient. I understand and agree that, if the patient's insurance requires genetic counseling prior to performance of the ordered test, PerkinElmer will provide the patient information to a third party service so the patient can obtain genetic counseling. I understand and agree that a genetic counselor will be permitted to review the test(s) I have ordered and make changes based on clinical or payor related specifications, and that the genetic counselor will submit to the payor the required documentation in support of the test as ordered or with any recommended changes. I attest that all information on this TRF is true to the best of my knowledge. My signature applies to the entirety of the statement above and/or attached letter of medical necessity.

Signature_____ Date_____

FOR INTERNAL USE ONLY				
Date Rec'd_____ Rec'd _____				
TEMP	SPEC	COL	#TUBES	VOL
R/C/F				
R/C/F				
R/C/F				

250 Industry Drive, Pittsburgh, PA 15275
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■ INSURANCE BILLING (Include a copy of both sides of insurance card)

Insurance Carrier

Insurance ID

Policy Holder Name

Policy Holder DOB MM/ DD /YYYY

Policy Holder Relationship to Patient: ○ Self ○ Parent ○ Spouse ○ Other:_____

Benefit Investigation and Out-of-Pocket Cost Policy

PerkinElmer will contact the patient for any estimated out-of-pocket costs that are greater than $100 USD before proceeding with testing. The patient's sample will be placed on hold (for up to 30 days) until authorization to proceed is received from the patient. If the patient does not respond to PerkinElmer within 30 days to discuss estimated out-of-pocket costs, the test order may be cancelled. Please note that failure by the patient to respond to PerkinElmer in a timely fashion regarding estimated out-of-pocket costs may cause a delay in the receipt of the results report.

Patient Billing Acknowledgement:

By signing this form, I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I hereby authorize PerkinElmer Genetics, Inc. ("PerkinElmer") to bill my designated insurance carrier(s) and share health information as needed for the purposes of billing and reimbursement, and I request that payment of authorized benefits be made on my behalf to PerkinElmer for any services furnished the patient listed above by PerkinElmer. If any insurance benefits are remitted to me for services performed by PerkinElmer for the patient, I will forward said benefits to PerkinElmer. I authorize PerkinElmer to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I agree to pay all charges for services provided by PerkinElmer to the patient which are not covered by my health insurance plan or which I am responsible for payment under my health insurance plan. Furthermore, I grant PerkinElmer permission to share health information with my insurance as needed for the purposes of billing and reimbursement.

Signature _____ Date _____

■ INSTITUTIONAL BILLING

Institution/Organization Name

PerkinElmer Genomics Billing Account ID

Contact Name

Contact Phone

■ PATIENT BILLING

○ **Check:** $_____ Amount Enclosed (Please make checks payable to: PerkinElmer Genetics, Inc.)

○ **Credit Card** (Please fill out all information):

Credit Card Number

CVV

Credit Card Billing Street Address

Card Exp. Date MM/YY

Cardholder Phone

City / Town

State

Zip Code

Cardholder Printed Name as Appears on Card

Cardholder Signature

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DETAILED MEDICAL RECORDS, CLINICAL SUMMARY, PICTURES AND FAMILY HISTORY MUST BE ATTACHED FOR ALL CASES.
CLINICAL INFORMATION IS CRUCIAL FOR ACCURATE INTERPRETATION OF RESULTS.

ADDITIONAL OPTIONAL PHENOTYPE / PATIENT HISTORY SECTION (Check all that apply)

Face2Gene ID (if applicable): _____

Clinical diagnosis: _____

Age of manifestation: _____ ICD-10 Codes: _____

A. NEUROLOGY

1. Behavioral abnormality
- ○ 1.1 Autism
- ○ 1.2 Attention deficit disorder
- ○ 1.3 Psychiatric diseases

2. Brain imaging
- ○ 2.1 Abnormal myelination
- ○ 2.2 Abnormal cortical gyration
- ○ 2.3 Agenesis of corpus callosum
- ○ 2.4 Brain atrophy
- ○ 2.5 Cerebellar hypoplasia
- ○ 2.6 Heterotopia
- ○ 2.7 Holoprosencephaly
- ○ 2.8 Hydrocephalus
- ○ 2.9 Leukodystrophy
- ○ 2.10 Lissencephaly

3. Developmental delay
- ○ 3.1 Delayed motor development
- ○ 3.2 Delayed language development
- ○ 3.3 Developmental regression
- ○ 3.4 Intellectual disability

4. Movement abnormality
- ○ 4.1 Ataxia
- ○ 4.2 Chorea
- ○ 4.3 Dystonia
- ○ 4.4 Parkinsonism

5. Neuromuscular abnormality
- ○ 5.1 Muscular hypotonia
- ○ 5.2 Muscular hypertonia
- ○ 5.3 Hyperreflexia
- ○ 5.4 Spasticity

6. Seizures
- ○ 6.1 Febrile seizures
- ○ 6.2 Focal seizures
- ○ 6.3 Generalized seizures

7. Others
- ○ 7.1 Craniosynostosis
- ○ 7.2 Dementia
- ○ 7.3 Encephalopathy
- ○ 7.4 Headache / Migraine
- ○ 7.5 Macrocephaly
- ○ 7.6 Microcephaly
- ○ 7.7 Neuropathy
- ○ 7.8 Stroke

B. METABOLISM
- ○ 1. Abnormal creatine kinase
- ○ 2. Decreased plasma carnitine
- ○ 3. Hyperalaninemia
- ○ 4. Hypoglycemia
- ○ 5. Increased CSF lactate
- ○ 6. Increased serum pyruvate
- ○ 7. Ketosis
- ○ 8. Lactic acidosis
- ○ 9. Organic aciduria

C. EYE
- ○ 1. Blepharospasm
- ○ 2. Cataract
- ○ 3. Coloboma
- ○ 4. Glaucoma
- ○ 5. Microphthalmos
- ○ 6. Nystagmus
- ○ 7. Ophthalmoplegia
- ○ 8. Optic atrophy
- ○ 9. Ptosis
- ○ 10. Retinitis pigmentosa
- ○ 11. Retinoblastoma
- ○ 12. Strabismus
- ○ 13. Visual impairment

D. MOUTH, THROAT AND EAR
- ○ 1. Abnormality of dental color
- ○ 2. Cleft lip / palate
- ○ 3. Conductive hearing impair.
- ○ 4. External ear malformation
- ○ 5. Hypodontia
- ○ 6. Sensoneural hearing impair.

E. SKIN, INTEGUMENT AND SKELETAL

1. Skeletal
- ○ 1.1 Abnormal limb morphology
- ○ 1.2 Abnormal skeletal system
- ○ 1.3 Abnormal vertebral column
- ○ 1.4 Joint hypermobility
- ○ 1.5 Multiple joint contractures
- ○ 1.6 Polydactyly
- ○ 1.7 Scoliosis
- ○ 1.8 Syndactyly
- ○ 1.9 Talipes equinovarus

2. Skin and integument
- ○ 2.1 Abnormal skin pigmentation
- ○ 2.2 Abnormal hair
- ○ 2.3 Abnormal nail
- ○ 2.4 Hyperextensible skin
- ○ 2.5 Ichthyosis

F. CARDIOVASCULAR
- ○ 1. Angioedema
- ○ 2. Aortic dilatation
- ○ 3. Arrhythmia
- ○ 4. Coarctation of aorta
- ○ 5. Defect of atrial septum
- ○ 6. Defect of ventricular septum
- ○ 7. Dilated cardiomyopathy
- ○ 8. Hypertension
- ○ 9. Hypertrophic cardiomyopathy
- ○ 10. Hypotension
- ○ 11. Lymphedema
- ○ 12. Malf. of heart and great vessels
- ○ 13. Myocardial infarction
- ○ 14. Stroke
- ○ 15. Tetralogy of Fallot
- ○ 16. Vasculitis

G. GASTROINTESTINAL, GENITOURINARY, ENDOCRINE

1. Gastrointestinal
- ○ 1.1 Aganglionic megacolon
- ○ 1.2 Constipation
- ○ 1.3 Diarrhea
- ○ 1.4 High hepatic transaminases
- ○ 1.5 Gastroschisis
- ○ 1.6 Hepatic failure
- ○ 1.7 Hepatomegaly
- ○ 1.8 Obesity
- ○ 1.9 Pyloric stenosis
- ○ 1.10 Vomiting

2. Genitourinary
- ○ 2.1 Abnormal renal morphology
- ○ 2.2 Abnormal urinary system
- ○ 2.3 Hydronephrosis
- ○ 2.4 Renal agenesis
- ○ 2.5 Renal cyst
- ○ 2.6 Renal tubular dysfunction

3. Endocrine
- ○ 3.1 Diabetes mellitus
- ○ 3.2 Hypo / hyperparathyroidism
- ○ 3.3 Hypo / hyperthyroidism

H. REPRODUCTION
- ○ 1. Abnormal external genitalia
- ○ 2. Abnormal internal genitalia
- ○ 3. Hypogonadism
- ○ 4. Hypospadias
- ○ 5. Infertility

I. ONCOLOGY
- ○ 1. Adenomatous polyposis
- ○ 2. Breast carcinoma
- ○ 3. Colorectal carcinoma
- ○ 4. Leukemia
- ○ 5. Myelofibrosis
- ○ 6. Neoplasm of the lung
- ○ 7. Neoplasm of the skin
- ○ 8. Paraganglioma
- ○ 9. Pheochromocytoma

J. HEMATOLOGY AND IMMUNOLOGY
- ○ 1. Abnormality of coagulation
- ○ 2. Anemia
- ○ 3. Immunodeficiency
- ○ 4. Neutropenia
- ○ 5. Pancytopenia
- ○ 6. Abnormal hemoglobin
- ○ 7. Splenomegaly
- ○ 8. Thrombocytopenia

K. PRENATAL AND DEVELOPMENT
- ○ 1. Dysmorphic facial features
- ○ 2. Failure to thrive
- ○ 3. Hemihypertrophy
- ○ 4. Hydrops fetalis
- ○ 5. IUGR
- ○ 6. Oligohydramnios
- ○ 7. Overgrowth
- ○ 8. Polyhydramnios
- ○ 9. Premature birth
- ○ 10. Short stature
- ○ 11. Tall stature

OTHER:

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