



# NGS Panel Request Form

106 Gregor Mendel Circle • Greenwood, SC 29646  
 Toll Free: (800) 473-9411 • Fax: (864) 941-8141  
 Website: [www.ggc.org](http://www.ggc.org) Highlighted boxes are required

LAB USE ONLY

**Patient Information (Please Print):**

Last Name		First	MI	Address			
Race/Ethnicity			Sex <input type="checkbox"/> M <input type="checkbox"/> F		DOB MM/DD/YYYY		City, State, Zip
Specimen Collection Date MM/DD/YYYY		Type of specimen*		Numeric Identifier (Medical record # or SSN)		Home telephone	
*DNA samples only: Please identify where DNA extraction was performed and source of DNA (blood, fibroblasts, etc.). <input type="checkbox"/> CAP/CLIA Accredited Lab: _____ <input type="checkbox"/> Research Lab: _____ <input type="checkbox"/> Unknown							

**Referring Physician:**

Name		Address					
Institution		City, State, Zip					
NPI#		Telephone				Fax	
Email Address:		Preferred Method to Receive Results: <input type="checkbox"/> Secure Email <input type="checkbox"/> Fax <input type="checkbox"/> Regular Mail					

**Additional report to:**  Genetic Counselor  Institution  Care Coordinator  Other:

Name		Address					
Telephone	Fax	Email:			City, State, Zip		

**Additional report to:**  Genetic Counselor  Institution  Care Coordinator  Other:

Name		Address					
Telephone	Fax	Email:			City, State, Zip		

**Billing:** Select how the test(s) will be billed & complete the billing information on the next page. **The BILLING FORM on page 2 is required.**

- Institutional Billing:** Complete section 1 on the separate [BILLING FORM](#) (page 2)
- Insurance:** Complete section 2 on the [BILLING FORM](#) (page 2). **MEDICAID FOR OUT-OF-STATE (NON-SC) PATIENTS IS NOT ACCEPTED.**
- Self-pay:** Complete section 3 on the separate [BILLING FORM](#) (page 2).

**Indication for Study & Clinical Information:**

ICD10 Code(s): \_\_\_\_\_

Symptomatic, specific findings: \_\_\_\_\_

Is the patient currently pregnant?  No  Yes If so, provide LMP: \_\_\_\_\_ or EDC: \_\_\_\_\_ Gestational Age: \_\_\_\_\_

Ultrasound findings \_\_\_\_\_

**Please attach pedigree**

Select panels may be requested for prenatal samples, and targeted mutation analysis may be available for familial pathogenic variants previously identified on one of these panels. Please contact the laboratory prior to sending prenatal samples.

**Maternal cell contamination studies are required for prenatal testing. Please send 4-5 ml of maternal blood in EDTA tube.**

- Maternal Cell Contamination

Comments:

\_\_\_\_\_

\_\_\_\_\_

**Specimen Requirements:** 4-5 ml of peripheral blood collected in an EDTA (lavender top) Vacutainer tube. The specimen should be kept at room temperature and delivered via overnight shipping.

**Please complete the Clinical Information on page 4.**

<b>LAB USE ONLY</b>		Accessioned By:		Event Codes:		FedEx		Eagle	UPS	DHL	WC	Other:
EDTA	Na Hep	Plasma / Serum	Urine	Flasks / Tissue	DBS / DNA	Saliva / Swab Buccal	PAX	ACD				
RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F



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- **Out of State (non-SC) commercial insurance can only be filed for NGS Panels.**
- **No out of state (non-SC) Medicaid will be accepted for any tests.**
- **The following items are needed in order to bill the patient's insurance directly. We will not be able to file the claim if we are missing information.**
  - This form must be completed with ALL requested information.**
  - A legible copy of both sides of the insurance card**
  - Authorization number, authorization letter, or letter of agreement from insurance company**

**Patient Information:**

Last Name	First	MI	Address	
Numeric Identifier (Medical record # or SSN)		DOB MM/DD/YYYY	City, State, Zip	Telephone
ICD10 Code(s)				

**Section 1: Institutional Billing**

Complete section below with institution information. \*New clients must complete an [INSTITUTIONAL ACCOUNT REQUEST FORM](#) when submitting the order.\* Please contact the GGC Billing Office at 864-941-8117 or [billing@ggc.org](mailto:billing@ggc.org) with any questions about your account.

Institution/Organization	Contact Name:	Email:
Billing Address	City, State, Zip	
Account Number:	Telephone	Fax

**Section 2: Insurance Information**      **MEDICAID FOR OUT-OF-STATE (NON-SC) PATIENTS IS NOT ACCEPTED**  
**MUST INCLUDE LEGIBLE COPY OF INSURANCE CARD (FRONT & BACK)**  
**All information required to file insurance claims.**

Primary		
Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone
Secondary		
Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone

I authorize Greenwood Genetic Center (GGC) Diagnostic Laboratories to furnish any medical information requested of me, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to GGC Diagnostic Laboratories. I understand I am responsible for any co-pay, deductibles, non-authorized, or non-covered services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if the GGC Diagnostic Laboratories is not a participant with my health plan, or my health plan does not fully reimburse my medical services due to lack of authorization for medical necessity.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date (MM/DD/YY): \_\_\_\_\_

**Section 3: Self-pay**

**We accept check/Visa/MasterCard. All information required to process credit card payments.**  
**Payments will be processed prior to initiation of testing.**

Payment Method: <input type="checkbox"/> Check <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	Credit Card Number:	
Amount: (with discount applied if applicable)	Exp. Date	CVV
Cardholder Name(print as it appears on the card):	Cardholder Signature:	Date
Billing address	City, State, Zip	Telephone



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Last Name	First	MI	DOB	Numeric Identifier
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- Aortic Dysfunction/Dilation & Related Disorders Panel (20 genes)
- Bardet-Biedl Syndrome Panel (26 genes)
- Brugada Syndrome Panel (18 genes)
- Central Hypoventilation Syndrome Panel (3 genes)
- Charcot-Marie-Tooth Hereditary Neuropathy Panel (54 genes)
- Charcot-Marie-Tooth Tiered Testing includes
  - Tier 1: Charcot-Marie-Tooth, Type IA (*PMP22*) MLPA with automatic reflex if normal to Tier 2
  - Tier 2: Charcot-Marie-Tooth Hereditary Neuropathy Panel (54 genes)
- Coffin-Siris Syndrome Panel (22 genes)
- Comprehensive Cardiac Panel (108 genes)
- Comprehensive Pulmonary Panel (124 genes)
- Cone-Rod Dystrophy Panel (37 genes)
- Congenital Contractures Panel (57 genes)
- Congenital Stationary Night Blindness Panel (15 genes)
- Connective Tissue Disorders Panel (35 genes)
- Cornelia de Lange Panel (5 genes)
- Craniosynostosis Panel (8 genes)
- Dilated Cardiomyopathy (DCM)/Arrhythmogenic Cardiomyopathy Panel (51 genes)
- Dyskeratosis Congenita Panel (14 genes)
- Early Infantile Epileptic Encephalopathy Panel (86 genes)
- Epilepsy/Seizure Panel (145 genes)
- Familial Hypercholesterolemia Panel (4 genes)
- Familial Hypercholesterolemia Tiered Testing includes
  - Tier 1: Familial Hypercholesterolemia Panel (4 genes) with automatic reflex if normal to Tier 2
  - Tier 2: Familial Hypercholesterolemia (*LDLR*) MLPA
- Hearing Loss Panel (91 genes)
- Hereditary Spastic Paraplegia Panel (79 genes)
- Hermansky-Pudlak Syndrome and Pulmonary Fibrosis Panel (40 genes)
- Hydrops Panel (87 genes)
- Hypertrophic Cardiomyopathy Panel (24 genes)
- Kallmann Syndrome and Hypogonadotropic Hypogonadism Panel (39 genes)
- Leber Congenital Amaurosis Panel (24 genes)
- Long QT Syndrome Panel (18 genes)
- Lysosomal Storage Disorders Panel (75 genes)
- Macular Degeneration Panel (24 genes)
- Maturity-Onset Diabetes of the Young Panel (14 genes)
- Mitochondrial Depletion Panel (23 genes)
- Neuromuscular Disorders Panel (144 genes)
- Neuronal Ceroid Lipofuscinoses Panel (9 genes)
- Ocular Albinism and Hermansky-Pudlak Syndrome Panel (18 genes)
- Optic Atrophy and Early Glaucoma Panel (34 genes)
- Overgrowth/Macrocephaly Panel (16 genes)
- Periodic Fever Panel (14 genes)
- Peroxisomal Biogenesis Disorders Panel (12 genes)
- Primary Ciliary Dyskinesia and Cystic Fibrosis Panel (42 genes)
- Pulmonary Arterial Hypertension Panel (22 genes)
- RASopathy Panel (23 genes)
- Retinitis Pigmentosa Panel (92 genes)
- Rett/Angelman Syndrome Panel (21 genes)
- Rhabdomyolysis and Metabolic Myopathies Panel (47 genes)
- Skeletal Dysplasia Panel (11 genes)
- Surfactant Dysfunction and Respiratory Distress in Premature Infants Panel (11 genes)
- Syndromic Autism Panel (83 genes)
- Tuberous Sclerosis Complex Panel (2 genes)
- Vascular Disorders Panel (21 genes)
- X-Linked Intellectual Disability (XLID) Panel (114 genes)

**Focused NGS Custom Requests** Specify the gene(s): \_\_\_\_\_  
 Available for most single genes and custom panel requests up to 20 genes. Please contact the laboratory prior to submission to confirm coverage of the requested genes.

**Deletion/Duplication Analysis for Selected Panel or Custom Panel Indicated Above (Separate charges will apply)**  
 Do you want the deletion/duplication analysis run  **Simultaneously** OR  **Sequentially** with the sequencing panel?

**Follow-up studies for Known Familial Variant** Specify gene & mutation: \_\_\_\_\_

Proband Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ Symptomatic:  Yes  No

**Reflex to QUICK Analysis if requested above testing is not informative** (no charge for this reflex)



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Please provide clinical information regarding the proband being tested. Check all that apply. If a feature is selected, please provide an additional description of the finding. Use blank space on right to provide other relevant details.

<p><b>Growth</b></p> <p><input type="checkbox"/> Failure to thrive _____</p> <p><input type="checkbox"/> Microcephaly (OFC &lt;3<sup>rd</sup> centile) _____</p> <p><input type="checkbox"/> Macrocephaly (OFC &gt;97<sup>th</sup> centile) _____</p> <p><input type="checkbox"/> Short stature (Ht &lt;3<sup>rd</sup> centile) _____</p> <p><input type="checkbox"/> Tall stature (Ht &gt;97<sup>th</sup> centile) _____</p> <p><input type="checkbox"/> Obesity/Overgrowth _____</p> <p><b>Neurological/Muscular</b></p> <p><input type="checkbox"/> Spasticity/Hyperreflexia _____</p> <p><input type="checkbox"/> Ataxia _____</p> <p><input type="checkbox"/> Tremors _____</p> <p><input type="checkbox"/> Hypotonia _____</p> <p><input type="checkbox"/> Seizures _____</p> <p><input type="checkbox"/> Abnormal movements _____</p> <p><b>Development, Physical &amp; Cognitive</b></p> <p><input type="checkbox"/> Delayed motor milestones _____</p> <p><input type="checkbox"/> Intellectual disability _____</p> <p><input type="checkbox"/> Speech/Language delay _____</p> <p><input type="checkbox"/> Developmental regression _____</p> <p><b>Craniofacial, Ophthalmologic, Auditory</b></p> <p><input type="checkbox"/> Vision Loss _____</p> <p><input type="checkbox"/> Hearing loss/Deafness _____</p> <p><input type="checkbox"/> Dysmorphic facies _____</p> <p><input type="checkbox"/> Eye anomalies _____</p> <p><input type="checkbox"/> Ear anomalies _____</p> <p><b>Skeletal &amp; Limb Anomalies</b></p> <p><input type="checkbox"/> Limb malformation _____</p> <p><input type="checkbox"/> Joint contractures _____</p> <p><input type="checkbox"/> Craniosynostosis _____</p> <p><input type="checkbox"/> Hyperextensibility _____</p> <p><b>Congenital Anomalies</b></p> <p><input type="checkbox"/> Heart malformations _____</p> <p><input type="checkbox"/> Kidney abnormalities _____</p> <p><input type="checkbox"/> Genital abnormality _____</p> <p><input type="checkbox"/> Brain malformations _____</p> <p><input type="checkbox"/> Gastrointestinal anomalies _____</p> <p><input type="checkbox"/> Other _____</p> <p><b>Other Features</b></p> <p><input type="checkbox"/> Prematurity _____</p> <p><input type="checkbox"/> Intrauterine growth restriction _____</p> <p><input type="checkbox"/> Autism/Autism Spectrum Disorders _____</p> <p><input type="checkbox"/> Metabolic abnormalities _____</p> <p><input type="checkbox"/> Mitochondrial abnormalities _____</p> <p><input type="checkbox"/> Pigmentary abnormalities _____</p> <p><input type="checkbox"/> Other skin findings _____</p> <p><input type="checkbox"/> Organomegaly _____</p> <p><input type="checkbox"/> Cancer/tumor formation _____</p> <p><b>You may also attach a pedigree and/or clinic note as additional supporting information.</b></p>	<p><b>Additional Information</b></p>
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