



NGS Panel Request Form

106 Gregor Mendel Circle • Greenwood, SC 29646
 Toll Free: (800) 473-9411 • Fax: (864) 941-8141
 Website: 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). WE DO NOT ACCEPT BCBS OR MEDICAID FOR NON-SC PATIENTS.
- 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 3-5 ml of maternal blood in EDTA tube.

Maternal Cell Contamination

Comments:

Specimen Requirements: 3-5 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.

LAB USE ONLY		Accessioned By:		Event Codes:		FedEx		Eagle	UPS	DHL	WC	USPS	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	RT / R / F



LAB USE ONLY

- **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 with any questions about your account.

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

Section 2: Insurance Information WE DO NOT ACCEPT BCBS OR MEDICAID FOR NON-SC PATIENTS. 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/American Express/Discover. 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 <input type="checkbox"/> AmEx <input type="checkbox"/> Discover	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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- 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)
- Cholestasis Panel (73 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 (165 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)
- Tuberos Sclerosis Complex Panel (2 genes)
- Vascular Disorders Panel (21 genes)
- X-Linked Intellectual Disability (XLID) Panel (114 genes)

Reflex to QUICK Analysis if sequencing panel above is not informative (no charge for this reflex)

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

Focused NGS Custom Requests Specify the gene(s): _____

Available for most single genes and custom panel requests up to 60 genes. Please contact the laboratory prior to submission to confirm coverage of the requested genes.

Follow-up studies for Known Familial Variant Specify gene & mutation: _____ Symptomatic: Yes No

Proband Name: _____ DOB: _____ Relationship: _____

Mitochondrial (mtDNA) Analysis

- Common 29 Variant Panel
- Expanded 93 Variant Panel
- Targeted Sanger Analysis: Known Familial Mutation
 - Specify variant: _____ Symptomatic: Yes No
 - If proband tested at GGC: Name _____ DOB: _____ Relationship: _____
- Targeted NGS Analysis with Heteroplasmy: Known Familial Mutation



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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.

- Growth**
- Failure to thrive _____
 - Microcephaly (OFC <3rd centile) _____
 - Macrocephaly (OFC >97th centile) _____
 - Short stature (Ht <3rd centile) _____
 - Tall stature (Ht >97th centile) _____
 - Obesity/Overgrowth _____
- Neurological/Muscular**
- Spasticity/Hyperreflexia _____
 - Ataxia _____
 - Tremors _____
 - Hypotonia _____
 - Seizures _____
 - Abnormal movements _____
- Development, Physical & Cognitive**
- Delayed motor milestones _____
 - Intellectual disability _____
 - Speech/Language delay _____
 - Developmental regression _____
- Craniofacial, Ophthalmologic, Auditory**
- Vision Loss _____
 - Hearing loss/Deafness _____
 - Dysmorphic facies _____
 - Eye anomalies _____
 - Ear anomalies _____
- Skeletal & Limb Anomalies**
- Limb malformation _____
 - Joint contractures _____
 - Craniosynostosis _____
 - Hyperextensibility _____
- Congenital Anomalies**
- Heart malformations _____
 - Kidney abnormalities _____
 - Genital abnormality _____
 - Brain malformations _____
 - Gastrointestinal anomalies _____
 - Other _____
- Other Features**
- Prematurity _____
 - Intrauterine growth restriction _____
 - Autism/Autism Spectrum Disorders _____
 - Metabolic abnormalities _____
 - Mitochondrial abnormalities _____
 - Pigmentary abnormalities _____
 - Other skin findings _____
 - Organomegaly _____
 - Cancer/tumor formation _____

Additional Information

You may also attach a pedigree and/or clinic note as additional supporting information.