



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 or a saliva sample.

- 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. Extracted DNA and saliva are also accepted unless otherwise indicated.

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
ICD10 Code(s)		Telephone	

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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Last Name	First	MI	DOB	Numeric Identifier
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- | | |
|---|---|
| <input type="checkbox"/> Aortic Dysfunction/Dilation & Related Disorders Panel (20 genes)
<input type="checkbox"/> Bardet-Biedl Syndrome Panel (26 genes)
<input type="checkbox"/> Brugada Syndrome Panel (18 genes)
<input type="checkbox"/> Central Hypoventilation Syndrome Panel (3 genes)
<input type="checkbox"/> Charcot-Marie-Tooth Hereditary Neuropathy Panel (54 genes)
<input type="checkbox"/> Charcot-Marie-Tooth Tiered Testing includes
Tier 1: Charcot-Marie-Tooth, Type IA (<i>PMP22</i>) MLPA with automatic reflex if normal to Tier 2
Tier 2: Charcot-Marie-Tooth Hereditary Neuropathy Panel (54 genes)
<input type="checkbox"/> Cholestasis Panel (73 genes)
<input type="checkbox"/> Coffin-Siris Syndrome Panel (22 genes)
<input type="checkbox"/> Comprehensive Cardiac Panel (108 genes)
<input type="checkbox"/> Comprehensive Pulmonary Panel (124 genes)
<input type="checkbox"/> Cone-Rod Dystrophy Panel (37 genes)
<input type="checkbox"/> Congenital Contractures Panel (57 genes)
<input type="checkbox"/> Congenital Stationary Night Blindness Panel (15 genes)
<input type="checkbox"/> Connective Tissue Disorders Panel (35 genes)
<input type="checkbox"/> Cornelia de Lange Panel (5 genes)
<input type="checkbox"/> Craniosynostosis Panel (8 genes)
<input type="checkbox"/> Dilated Cardiomyopathy (DCM)/Arrhythmogenic Cardiomyopathy Panel (51 genes)
<input type="checkbox"/> Dyskeratosis Congenita Panel (14 genes)
<input type="checkbox"/> Early Infantile Epileptic Encephalopathy Panel (86 genes)
<input type="checkbox"/> Epilepsy/Seizure Panel (165 genes)
<input type="checkbox"/> Familial Hypercholesterolemia Panel (4 genes)
<input type="checkbox"/> Familial Hypercholesterolemia Tiered Testing includes
Tier 1: Familial Hypercholesterolemia Panel (4 genes) with automatic reflex if normal to Tier 2
Tier 2: Familial Hypercholesterolemia (<i>LDLR</i>) MLPA
<input type="checkbox"/> Hearing Loss Panel (91 genes)
<input type="checkbox"/> Hereditary Spastic Paraplegia Panel (79 genes) | <input type="checkbox"/> Hermansky-Pudlak Syndrome and Pulmonary Fibrosis Panel (40 genes)
<input type="checkbox"/> Hydrops Panel (87 genes)
<input type="checkbox"/> Hypertrophic Cardiomyopathy Panel (24 genes)
<input type="checkbox"/> Kallmann Syndrome and Hypogonadotropic Hypogonadism Panel (39 genes)
<input type="checkbox"/> Leber Congenital Amaurosis Panel (24 genes)
<input type="checkbox"/> Long QT Syndrome Panel (18 genes)
<input type="checkbox"/> Lysosomal Storage Disorders Panel (75 genes)
<input type="checkbox"/> Macular Degeneration Panel (24 genes)
<input type="checkbox"/> Maturity-Onset Diabetes of the Young Panel (14 genes)
<input type="checkbox"/> Mitochondrial Depletion Panel (23 genes)
<input type="checkbox"/> Neuromuscular Disorders Panel (144 genes)
<input type="checkbox"/> Neuronal Ceroid Lipofuscinoses Panel (9 genes)
<input type="checkbox"/> Ocular Albinism and Hermansky-Pudlak Syndrome Panel (18 genes)
<input type="checkbox"/> Optic Atrophy and Early Glaucoma Panel (34 genes)
<input type="checkbox"/> Overgrowth/Macrocephaly Panel (16 genes)
<input type="checkbox"/> Periodic Fever Panel (14 genes)
<input type="checkbox"/> Peroxisomal Biogenesis Disorders Panel (12 genes)
<input type="checkbox"/> Primary Ciliary Dyskinesia and Cystic Fibrosis Panel (42 genes)
<input type="checkbox"/> Pulmonary Arterial Hypertension Panel (22 genes)
<input type="checkbox"/> RASopathy Panel (23 genes)
<input type="checkbox"/> Retinitis Pigmentosa Panel (92 genes)
<input type="checkbox"/> Rett/Angelman Syndrome Panel (21 genes)
<input type="checkbox"/> Rhabdomyolysis and Metabolic Myopathies Panel (47 genes)
<input type="checkbox"/> Skeletal Dysplasia Panel (11 genes)
<input type="checkbox"/> Surfactant Dysfunction and Respiratory Distress in Premature Infants Panel (11 genes)
<input type="checkbox"/> Syndromic Autism Panel (83 genes)
<input type="checkbox"/> Tuberos Sclerosis Complex Panel (2 genes)
<input type="checkbox"/> Vascular Disorders Panel (21 genes)
<input type="checkbox"/> 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 to proband: _____

Mitochondrial (mtDNA) Analysis (Blood or DNA from blood only)

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



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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>Growth</p> <p><input type="checkbox"/> Failure to thrive _____</p> <p><input type="checkbox"/> Microcephaly (OFC <3rd centile) _____</p> <p><input type="checkbox"/> Macrocephaly (OFC >97th centile) _____</p> <p><input type="checkbox"/> Short stature (Ht <3rd centile) _____</p> <p><input type="checkbox"/> Tall stature (Ht >97th centile) _____</p> <p><input type="checkbox"/> Obesity/Overgrowth _____</p> <p>Neurological/Muscular</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>Development, Physical & Cognitive</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>Craniofacial, Ophthalmologic, Auditory</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>Skeletal & Limb Anomalies</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>Congenital Anomalies</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>Other Features</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>You may also attach a pedigree and/or clinic note as additional supporting information.</p>	<p style="text-align: center;">Additional Information</p>
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