quadrant laboratories

505 Irving Ave, Ste 3733, Syracuse, NY
13210 O: (866) 240-4485. F: (315) 666-1379

GENETIC TEST REQUISITION FORM

ORDER ID
Place collection kit barcode here

PATIENT INFORMATION

MRN/REF ID#

QUADRANT ACCOUNT ID #

LEGAL LAST NAME

LEGAL FIRST NAME

DATE OF BIRTH (MM/DD/YYYY)

BIOLOGICAL SEX
(check one)
☐ MALE ☐ FEMALE

GENDER
(if differs from biological sex at birth)
☐ MAN ☐ WOMAN
☐ NON-BINARY ☐ SELF-DESCRIBED

ANCESTRY
☐ AMERICAN/WHITE/CAUCASIAN ☐ ASHKENAZI JEWISH
☐ ASIAN ☐ BLACK/AFRICAN
☐ CANADIAN ☐ FRENCH
☐ HISPANIC ☐ NATIVE AMERICAN
☐ PACIFIC ISLANDER ☐ SEPHARDIC JEWISH
☐ OTHER

	BIOLOGICAL MOTHER	BIOLOGICAL FATHER
LAST NAME		
FIRST NAME		
DATE OF BIRTH	(MM/DD/YYYY)	(MM/DD/YYYY)

BILLING/PAYMENT INFORMATION

EMAIL ADDRESS
(billing and report access after clinician releases)

street address

City State/Province

Zip/Postal Code Country

BILLING SELECTION
(pick one)
☐ PATIENT PAY ☐ INSTITUTIONAL
☐ BILL INSURANCE

*** PATIENT PAY**
Please provide Credit/Debit/HSA card information via the Financial Responsibility & Consent form. Card will be run upon receipt of the sample and must be successfully processed before receiving the results of the test.

*** BILL INSURANCE**
Please provide insurance details via the Financial Responsibility & Consent form along with a copy of front and back of the insurance card(s). Any balance your insurance does not pay, will be due within 30 days upon receipt of the bill.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to the provider and I understand that I am financially responsible for uncovered services. I also authorize the release of any information required to process the claim. Billing inquiries, please call (866) 240-4485

SIGN HERE Parent/Guardian Signature (required) Date (MM/DD/YYYY)

SHIPPING INFORMATION

Ship a collection swab kit to this patient (to request kit shipment, submit this completed form to Client Services via fax (315) 666-1379 or email support@quadrantlaboratories.com

☐ Ship kit to address above ☐ Ship kit to an alternate address

Street address

City State/Province

PROVIDER INFORMATION

ORGANIZATION/CLINIC NAME

NPI #

ORDERING PHYSICIAN

GENETIC COUNSELOR

CLINIC ADDRESS

Street address

City State/Province

Zip/Postal Code Country

CLINIC PHONE NUMBER

CLINIC FAX NUMBER

CLINIC EMAIL ADDRESS

REPORT DELIVERY
☐ FAX ☐ EMAIL

ORDERING PROVIDER CERTIFICATION

I am authorized by law to order the test(s) requested herein. I certify that this is medically necessary for the diagnosis and detection of a disease/illness/ impairment/syndrome/disorder and that the result will be used to inform the patient's medical management and treatment. I authorize such testing for the reasons stated below and have explained it to the parent/guardian who has provided consent (an informed consent form is available below, for my convenience). I agree to cooperate with Quadrant Laboratories LLC in providing applicable treatment records for purposes of optimized test interpretation and insurance correspondence, if applicable.

SIGN HERE Provider signature of consent (required)

Date (MM/DD/YYYY)

SPECIMEN(S) INFORMATION

SAMPLE TYPE PATIENT
☐ PERIPHERAL ☐ BLOOD
☐ SALIVA ☐ OTHER

DATE OF COLLECTION
Date (MM/DD/YYYY)

SAMPLE TYPE BIOLOGICAL MOTHER
☐ PERIPHERAL ☐ BLOOD
☐ SALIVA ☐ OTHER

SAMPLE TYPE BIOLOGICAL FATHER
☐ PERIPHERAL ☐ BLOOD
☐ SALIVA ☐ OTHER

Parental samples will be used as needed in follow-up to patient testing. Please submit a separate signed informed consent form for each sample submitted (including parents).

PATIENT HAS HAD BLOOD TRANSFUSION
☐ YES ☐ NO

DATE OF TRANSFUSION
(2-4 weeks of wait time is required for some testing)
Date (MM/DD/YYYY)

PATIENT HAS AN ALLOGENIC BONE MARROW TRANSPLANT
☐ YES ☐ NO

Fibroblasts are recommended for patients who had an allogenic bone marrow transplant.

SEE TREATMENT-RELATED RUSH
☐ YES ☐ NO DATE

DATE OF TREATMENT
Date (MM/DD/YYYY)

Please provide ICD10(s) here and complete all clinical questions on the below pages (required) clinical indications.

TEST MENU - please select test(s) ordered from below (REQUIRED)

NEURODEVELOPMENTAL TESTS

- ☐ 1001 Autism Test NGS Panel
- ☐ 1002 Fragile X testing (FMR1 Repeat Analyses)*
- ☐ 1003 Chromosomal Microarray testing*

(*) blood sample required for additional testing

Any gene included on a panel may be ordered individually

- ☐ 1004 Single Gene Order
- ☐ Known Familial Variant(s) in a single gene _____
- ☐ Confirmation of variant identified in research lab

Office instructions: Complete all fields below and fax to (315) 666-1379 or email support@quadrantlaboratories.com

The accurate interpretation and reporting of genetic results relies on the provision of pertinent clinical and family history information. To help ensure the most clinically appropriate interpretation of results, complete the clinical phenotype details below. Select all that apply.

FAMILY HISTORY (PLEASE INCLUDE PEDIGREE)

If yes, please indicate any family relatives with clinical history of disease below

- ☐ Cognitive impairment: HP:0100543
- ☐ Global developmental delay HP:0001263
- ☐ Spontaneous abortion HP:0005268
- ☐ Stillbirth HP:0003826
- ☐ Other: _____
- ☐ No
- ☐ Unknown

Additional details:

_____

_____

_____

ICD-10 CODES

- ☐ F84.0 Autistic Disorder: HP:0000717
- ☐ Q04.9 Congenital malformation of brain unspecified
- ☐ F80.9 Developmental disorder of speech and language, unspecified
- ☐ Z00.121 Encounter for routine child health examination with abnormal findings
- ☐ Z13.42 Encounter for screening for global developmental delays (milestones)
- ☐ G40 Epilepsy and recurrent seizures HP:0001250
- ☐ F84.9 Pervasive developmental disorder unspecified
- ☐ F82 Specific developmental disorder of motor function
- ☐ F98.9 Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- ☐ R62.50 Unspecified lack of expected normal physiological development in childhood
- ☐ OTHER _____

HISTORY OF CONSANGUINITY

If yes, please submit pedigree if available

- ☐ Paternal Ancestry _____
- ☐ Maternal Ancestry _____
- ☐ No
- ☐ Unknown

HISTORY OF PREVIOUS TESTING (PLEASE ATTACH DETAILS)

If yes, please provide details below

- ☐ Chromosomal Microarray
- ☐ Fragile X Testing
- ☐ Karyotype
- ☐ Sequencing studies
- ☐ Other _____
- ☐ No
- ☐ Unknown

AGE OF ONSET

- ☐ Adult onset HP:0003581
- ☐ Childhood onset HP:0011463
- ☐ Congenital onset HP:0003577
- ☐ Infantile onset HP:0003593
- ☐ Neonatal onset HP:0003623
- ☐ Young Adult onset HP:0011462
- ☐ Other _____

OTHER FACTORS

If yes, please provide details below

- ☐ Alcohol withdrawal
- ☐ Drug/toxin-induced

_____
List drugs used (if known)

_____
List toxins exposed (if known)

- ☐ Head injury
- ☐ Known environmental risk factors
- ☐ Maternal teratogenic exposure HP:0011438
- ☐ Metabolic or electrolyte imbalance HP:0032180
- ☐ Systemic infection HP:0005429
- ☐ Condition triggered by sleep deprivation HP:0025222
- ☐ Condition triggered by stress HP:0025226
- ☐ Other _____

PERINATAL OR PRENATAL HISTORY

Please provide details below

- [ ] Hydrocephalus HP:0000238
- [ ] Intrauterine growth retardation HP:0001511
- [ ] Macrocephaly at birth HP:0004488
- [ ] Oligohydramnios HP:0001562
- [ ] Polyhydramnios HP:0001561
- [ ] Preeclampsia HP:0100602
- [ ] Premature birth HP:0001622
- [ ] Seizures HP:0001250
- [ ] Other _____
- [ ] No
- [ ] Unknown

BEHAVIORAL FINDINGS

Please provide details below

- [ ] Abnormal aggressive, impulsive or violent behavior HP:0006919
- [ ] Attention deficit hyperactivity disorder HP:0007018
- [ ] Autism HP:0000717
- [ ] Autistic behavior HP:0000729
- [ ] Hyperactivity HP:0000752
- [ ] Obsessive-compulsive behavior HP:0000722
- [ ] Psychiatric abnormalities HP:0000708
- [ ] Psychosis HP:0000709
- [ ] Short attention span HP:0000736
- [ ] Specific learning disability HP:0001328
- [ ] Stereotypy HP:0000733
- [ ] Aggressive behavior HP:0000718
- [ ] Other _____
- [ ] No
- [ ] Unknown

HEENT

- [ ] Cataract HP:0000518
- [ ] Cleft palate HP:0000175
- [ ] Cystic hygroma HP:0000476
- [ ] Downslanted palpebral fissures HP:0000494
- [ ] Epicanthus HP:0000286
- [ ] High palate HP:0000218
- [ ] Hypertelorism HP:0000316
- [ ] Lisch nodules HP:0009737
- [ ] Long philtrum HP:0000343
- [ ] Low-set ears HP:0000369
- [ ] Macrocephaly HP:0000256
- [ ] Macrotia HP:0000400
- [ ] Micrognathia HP:0000347
- [ ] Myopia HP:0000545
- [ ] Nystagmus HP:0000639
- [ ] Optic atrophy HP:0000648
- [ ] Posteriorly rotated ears HP:0000358
- [ ] Prominent nasal bridge HP:0000426
- [ ] Ptosis HP:0000508
- [ ] Short neck HP:0000470
- [ ] Sloping forehead HP:0000340
- [ ] Strabismus HP:0000486
- [ ] Webbed neck HP:0000465

SKIN

- [ ] Axillary freckling HP:0000997
- [ ] Eczema HP:0000964
- [ ] Inguinal freckling HP:0030052
- [ ] Multiple lentigines HP:0001003

CARDIAC

- [ ] Atrial septal defect HP:0001631
- [ ] Hypertrophic cardiomyopathy HP:0001639
- [ ] Pulmonic stenosis HP:0001642
- [ ] Ventricular septal defect HP:0001629

MUSCULOSKELETAL

- [ ] Club foot HP:0001762
- [ ] Joint flexibility HP:0005692
- [ ] Lymphedema HP:0001004
- [ ] Pectus excavatum HP:0000767
- [ ] Pes planus HP:0001763
- [ ] Scoliosis HP:0002650
- [ ] Syndactyly HP:0001159

HEME

- [ ] Abnormal bleeding HP:0001892

ENDO

- [ ] Cryptorchidism HP:0000028
- [ ] Micropenis HP:0000054
- [ ] Short stature HP:0004322

NEUROLOGICAL

- [ ] Absent speech HP:0001344
- [ ] Agenesis of corpus callosum HP:0001274
- [ ] Atonic seizures HP:0010819
- [ ] Cerebellar hypoplasia HP:0001321
- [ ] Cerebral atrophy HP:0002059
- [ ] Delayed speech and language development HP:0000750
- [ ] EEG abnormality HP:0002353
- [ ] Elevated serum creatine phosphokinase HP:0003236
- [ ] Epileptic encephalopathy HP:0200134
- [ ] Febrile seizures HP:0002373
- [ ] Flexion contracture HP:0001371
- [ ] Focal clonic seizures HP:0002266
- [ ] Focal seizures HP:0007359
- [ ] Generalized hypotonia HP:0001290
- [ ] Generalized myoclonic seizures HP:0002123
- [ ] Generalized seizures HP:0002197
- [ ] Generalized tonic-clonic seizures HP:0002069
- [ ] Global developmental delay HP:0001263
- [ ] Hydrocephalus HP:0000238
- [ ] Hyperreflexia HP:0001347
- [ ] Hypoplasia of the brainstem HP:0002365
- [ ] Hypoplasia of the corpus callosum HP:0002079
- [ ] Intellectual disability HP:0001249
- [ ] Lissencephaly HP:0001339
- [ ] Microcephaly HP:0000252
- [ ] Microphthalmia HP:0000568
- [ ] Migraine HP:0002076
- [ ] Motor delay HP:0001270
- [ ] Muscular hypotonia HP:0001252
- [ ] Neurofibromas HP:0001067
- [ ] Pachygyria HP:0001302
- [ ] Seizures HP:0001250
- [ ] Sensorineural hearing impairment HP:0000407
- [ ] Ventriculomegaly HP:0002119

GI

- [ ] Gastroesophageal reflux HP:0002020
- [ ] Failure to thrive HP:0001508
- [ ] Feeding difficulties HP:0011968