

505 Irving Ave, Ste 3733
 Syracuse, NY 13210
 O: (866) 240-4485 F: (315) 666-1379
 CLIA #33D2218809

For Quadrant Laboratories Use Only

Accession ID #
 Place accession ID sticker here >>>
 Date of sample collection

PATIENT INFORMATION (complete form for each person tested)

MRN/REF ID#	Date of Request
--------------------	------------------------

Legal Last Name	Legal First Name
------------------------	-------------------------

Date of Birth (MM/DD/YYYY)	Biological Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
-----------------------------------	--

Gender (if differs from biological sex at birth) <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Non-binary <input type="checkbox"/> Self-described
--	---

Ancestry <input type="checkbox"/> African/Black	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Sephardic Jewish
<input type="checkbox"/> American/White/Caucasian	<input type="checkbox"/> Canadian	<input type="checkbox"/> Native American	<input type="checkbox"/> Other
<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> French	<input type="checkbox"/> Pacific Islander	

Patient Sample Type <input type="checkbox"/> Saliva <input type="checkbox"/> Blood <input type="checkbox"/> Other	Date of Collection (MM/DD/YYYY)
---	--

Clinical Indication <input type="checkbox"/> Diagnostic/Affected <input type="checkbox"/> Presymptomatic/At Risk <input type="checkbox"/> Carrier Testing/Unaffected
--

Patient has had a blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	See treatment related rash <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has had an allogenic bone marrow transplant <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---	--

Date of Transfusion (MM/DD/YYYY)	Date of Treatment (MM/DD/YYYY)	Date of Transplant (MM/DD/YYYY)
---	---------------------------------------	--

A wait time of 2-4 weeks is required for some testing.

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

BIOLOGICAL MOTHER

Legal Last Name	Legal First Name	Date of Birth (MM/DD/YYYY)
------------------------	-------------------------	-----------------------------------

BIOLOGICAL FATHER

Legal Last Name	Legal First Name	Date of Birth (MM/DD/YYYY)
------------------------	-------------------------	-----------------------------------

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).

Please provide ICD-10 code(s) and complete all clinical questions on the below pages (required).

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

Neurodevelopmental Tests

- 1001** Autism/XL-Intellectual Disability Panel (NGS)
The Quadrant Laboratories' NGS panel is a comprehensive genetic panel that detects both single-nucleotide variants and copy number variants that are larger than 3 exons.
- 1002** Fragile X Testing (FMR1 Repeat Analyses)*
* Blood sample may be required for additional testing.

Individual Gene Tests

(any gene on the panel may be ordered individually)

- 1004** Single Gene Order
Known familial variant(s) in a single gene
- Confirmation of variant identified in lab

CLINICAL HISTORY

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.

Indicate any family relatives with a clinical history of disease below:

- Cognitive impairment **HP: 0100543**
- Global developmental delay **HP:001263**
- Spontaneous abortion **HP: 0005268**
- Stillbirth **HP: 003826**
- Unknown
- No relatives with a clinical history of disease
- Other

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
- F70-F79 Intellectual Disability **HP:0001249**
- Other

History of consanguinity, if yes please submit pedigree if available.

- Paternal ancestry
- Maternal ancestry
- Unknown
- No history of consanguinity

History of previous testing, if yes please provide details below.

- Chromosomal Microarray
- Fragile X Test
- Karyotype
- Sequencing Studies
- Unknown
- No history of previous testing
- Other

HUMAN PHENOTYPES AND OTHER FACTORS (please select all that apply)

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

PERINATAL OR PRENATAL HISTORY

- 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 perinatal or prenatal history
- 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**

OTHER FACTORS

If yes, please provide details below

- Alcohol withdrawal
- Drug/toxin-induced (list below 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

BEHAVIORAL FINDINGS

- 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 behavioral findings
- Unknown

ENDO

- Cryptorchidism **HP:0000028**
- Micropenis **HP:0000054**
- Short stature **HP:0004322**

HEENT CONTINUED

- 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 lentiginos **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**

GI

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

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**

SHIPPING INFORMATION

<input type="checkbox"/> Ship a sample collection kit to the patient at the address provided below	<input type="checkbox"/> Sample was collected at an inpatient clinic or other facility	
Patient Name	Ship Care Of	
Street Address		
City	State	Zip
Patient Phone Number	Patient Email	

BILLING SELECTION

<input type="checkbox"/> Patient Pay	<input type="checkbox"/> Bill Insurance	<input type="checkbox"/> Institutional
Responsible Party's Legal Name <i>(must be 18 years or older)</i>	Patient's Legal Name	
Email Address <i>(for billing/reporting)</i>	Mobile Phone Number <i>(for billing contact)</i>	
Financial Responsibility and Informed Consent forms will be sent via email to the responsible party once the benefits investigation is complete.		

INSURANCE INFORMATION - complete with policy holder's information

Indicate the type of insurance		
<input type="checkbox"/> Private	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid
Policy Holder Name	Date of Birth <i>(MM/DD/YYYY)</i>	Relationship to Patient
Primary Insurance Company Name <i>(required)</i>		Insurance Company Phone Number
Policy ID Number	Group ID Number	
Secondary Insurance Company Name <i>(if applicable)</i>		Insurance Company Phone Number
Policy Holder Name <i>(if differs from above)</i>	Date of Birth <i>(MM/DD/YYYY)</i>	Relationship to Patient
Policy ID Number	Group ID Number	
*Please attach a copy of any insurance cards referenced in this section (both sides of card required).		

ORDERING PROVIDER INFORMATION

Clinic Name		Clinic NPI Number	
Ordering Provider Name	Provider NPI Number	Genetic Counselor Name	
Clinic Street Address			
City		State/Province	
Zip/Postal Code		Country	
Clinic Phone Number		Clinic Fax Number	
Clinic Email Address		Preferred Report Delivery Method <input type="checkbox"/> Fax <input type="checkbox"/> 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 above and have explained it to the parent/guardian who has provided consent (an informed consent form is available, for my convenience). I agree to cooperate with Quadrant Laboratories LLC in providing treatment records for purposes of optimized test interpretation and insurance correspondence, if applicable.

SIGN 

Provider Signature of Consent (**required**)

Date (MM/DD/YYYY)

Please send this form via:

Fax: (315) 666-1379 **or**

Email: support@quadrantlaboratories.com

Results of the insurance benefit investigations will be delivered via the guarantor's email address listed above. Please ensure to list a good contact email address and/or phone number for us to reach out once the results are complete.