



# Patient and Specimen Information Form

5424 Glenridge Drive NE | Atlanta, GA 30342 USA | phone: 844.664.8378 | fax: 678.225.0212 | mnglabs.com

## Patient and Specimen Information

Patient Last Name		Patient First Name	
Patient ID #		Date of Birth [MM/DD/YYYY]	
Diagnosis/ICD-10		Collection Date [MM/DD/YYYY]	
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Specimen Type</b> <input type="checkbox"/> Whole Blood <input type="checkbox"/> Buccal Swab	<input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Fibroblasts	<input type="checkbox"/> Plasma/Serum <input type="checkbox"/> DNA Tissue: _____ <input type="checkbox"/> Muscle

**Please complete and include clinical information form, or attach clinical notes**

## Referring Physician Information

Physician Name		NPI # or equivalent (Required)	
Facility / Organization		Signature	
Facility Address City, State, Zip Code		<input type="checkbox"/> Same as billing	
Report Delivery <input type="checkbox"/> Fax	<input type="checkbox"/> Email	Phone	

## Billing Information (REQUIRED)

Self-Pay? <input type="checkbox"/> Yes		If yes, <b>MUST</b> include payer contact name & details below. Payment must be received in full prior to testing.	
Facility		Contact Name	
Billing Address			
City, State, Zip Code			
Phone	Fax	Email	

## Results

Authorized Recipient Name		Authorized Recipient Name	
Facility		Facility	
Phone		Phone	
<input type="checkbox"/> Fax		<input type="checkbox"/> Fax	
<input type="checkbox"/> Email		<input type="checkbox"/> Email	

## Testing Checklist

All of the following are encouraged to be included with test orders (please check the following):

- All specimens that will be analyzed must be received - please note if samples will ship separately
- Clinical Information Form completed
- Informed Consent for Genetic Testing completed and signed



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Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

### Epilepsy

- (NGS385) Comprehensive Epilepsy + mtDNA
- (NGS503) Clinical Epilepsy
- (NGS412) Myoclonic Epilepsy
- (NGS386) Epileptic Encephalopathy

### Movement Disorders

#### Ataxia / Episodic Ataxia

- (NGS324) Ataxia/Episodic Ataxia Disorders + mtDNA
- (NGS408) Ataxia/Episodic Ataxia Disorders + mtDNA + HTT Repeat Expansion
- (NGS417) Ataxia/Episodic Ataxia Disorders + mtDNA + SCA & HTT Repeat Expansions
- (NGS419) Ataxia/Episodic Ataxia Disorders + mtDNA + FRDA Repeat Expansions
- (NGS420) Ataxia/Episodic Ataxia Disorders + mtDNA + SCA & FRDA Repeat Expansions
- (NGS431) Ataxia/Episodic Ataxia Disorders + mtDNA + SCA Repeat Expansions

#### Dystonias

- (NGS358) Comprehensive Dystonia + mtDNA
- (NGS409) Comprehensive Dystonia + mtDNA + HTT Repeat Expansions
- (NGS357) Parkinsons Disease/Parkinsonism
- (NGS360) Basal Ganglia Calcification Dystonia
- (NGS361) OXPHOS Defect Dystonia + mtDNA
- (NGS446) Dopa-Responsive Dystonia
- (NGS359) Primary Dystonia

### Neuromuscular

#### Muscular Dystrophy / Myopathy

- (NGS330) Comprehensive Muscular Dystrophy/Myopathy + mtDNA
- (NGS331) Congenital Myasthenic Syndromes
- (NGS332) Hypokalemic & Hyperkalemic Periodic Paralysis
- (NGS333) Malignant Hyperthermia
- (NGS447) Sarcoglycanopathies
- (NGS348) Fetal Akinesia, Arthrogryposis, or Contractures
- (NGS413) Congenital Myopathies
- (NGS421) Congenital Muscular Dystrophies
- (NGS422) Limb-Girdle Muscular Dystrophy
- (NGS423) Emery-Dreifuss Muscular Dystrophy
- (NGS424) Duchenne/Becker Muscular Dystrophy
- (NGS448) Hyperekplexia

#### Neuropathies

- (NGS445) Comprehensive Neuropathies
- (NGS323) Amyotrophic Lateral Sclerosis
- (NGS405) Amyotrophic Lateral Sclerosis + C9orf72 Repeat Expansion
- (NGS346) Hereditary Sensory & Autonomic Neuropathy
- (NGS400) Pain Syndromes
- (NGS345) Charcot-Marie-Tooth Disease + mtDNA
- (NGS345A) **AXONAL** Charcot-Marie-Tooth Disease + mtDNA
- (NGS345D) **DEMYELINATING** Charcot-Marie-Tooth Disease + mtDNA
- (NGS347) Spinal Muscular Atrophy
- (NGS337) Spastic Paraplegia + mtDNA
- (NGS465) Dysautonomia

### Neurobehavioral

#### Intellectual Disability / Autism

- (NGS325) Comprehensive Intellectual Disability/Autism + mtDNA
- (NGS432) Comprehensive Intellectual Disability/Autism + Fragile X Repeat Expansion & Methylation + mtDNA
- (NGS427) X-linked Intellectual Disability + Fragile X Repeat Expansion and Methylation
- (NGS349) Nonsyndromic Intellectual Disability
- (NGS350) Syndromic Intellectual Disability
- (NGS398) Macrocephaly & Overgrowth Syndrome
- (NGS425) Microcephaly
- (NGS426) Hydrocephalus
- (NGS453) Cornelia de Lange

#### Neurodegeneration

- (NGS376) Comprehensive Dementia
- (NGS407) Comprehensive Dementia + C9orf72 Repeat Expansion
- (NGS410) Comprehensive Dementia + HTT Repeat Expansion
- (NGS411) Comprehensive Dementia + C9orf72 & HTT Repeat Expansions
- (NGS356) Alzheimer Disease/Frontotemporal Dementia
- (NGS406) Alzheimer Disease/Frontotemporal Dementia + C9orf72 Repeat Expansion
- (NGS380) Amyloid Related Disorders
- (NGS362) Neurodegeneration with Brain Iron Accumulation

#### Brain Malformation Disorders

- (NGS372) Comprehensive Leukodystrophy/ Leukoencephalopathy + mtDNA
- (NGS373) Non-Mitochondrial Leukodystrophy/Leukoencephalopathy
- (NGS374) Mitochondrial Leukodystrophy/Leukoencephalopathy + mtDNA
- (NGS375) Vanishing White Matter, Dysmyelinating, & Hypomyelinating Leukodystrophy
- (NGS387) Comprehensive Neuronal Migration Disorders + mtDNA
- (NGS388) Non-Mitochondrial Neuronal Migration Disorders
- (NGS389) Mitochondrial Neuronal Migration Disorders + mtDNA
- (NGS394) Joubert Syndrome
- (NGS395) Meckel Syndrome
- (NGS454) Polymicrogyria
- (NGS455) Lissencephaly
- (NGS456) Cerebral Cavernous Malformations
- (NGS457) Holoprosencephaly



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Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

## Neurometabolic

### Neurotransmitter Deficiencies

- (NGS315) Neurotransmitter Metabolism Deficiency
- (NGS310) GABA Metabolism Deficiency
- (NGS316) Dopamine Metabolism Deficiency
- (NGS317) Serotonin Metabolism Deficiency
- (NGS318) Tetrahydrofolate Metabolism Deficiency
- (NGS320) Tyrosinemia
- (NGS344) Aicardi-Goutieres Syndrome

### Mitochondrial & Cellular Energetics Deficiencies

- (NGS301) Comprehensive Cellular Energetics Defects + mtDNA
- (NGS197) Coenzyme Q10 Deficiency
- (NGS198) Comprehensive mtDNA Depletion Syndromes
- (NGS306) Oxidative Phosphorylation (OXPHOS) Defects + mtDNA
- (NGS302) Carbohydrate Metabolism Deficiency + mtDNA
- (NGS303) Lipid Metabolism Deficiency + mtDNA
- (NGS304) Pyruvate Metabolism Disorders + mtDNA
- (NGS305) PDH/Tricarboxylic Acid Cycle Defects + mtDNA
- (NGS308) Creatine Metabolism Deficiency
- (NGS311) Glutaric Acidemia Disorders
- (NGS312) Ketone Body Metabolism Deficiency
- (NGS355) Cytochrome C Oxidase Deficiency + mtDNA
- (NGS351) Leigh Disease + mtDNA

### Metabolic Pathway Disorders

- (NGS307) Ceroid Lipofuscinosis Disorders
- (NGS309) Cobalamin/Homocysteine/Methionine Metabolism Deficiency
- (NGS314) Methylmalonic Acid Metabolism Deficiency
- (NGS321) Urea Cycle Disorders
- (NGS327) Congenital Glycosylation Disorders
- (NGS383) Comprehensive Metabolic Disease Hepatomegaly + mtDNA
- (NGS384) Carbohydrate Metabolism Hepatomegaly
- (NGS449) Hyperphenylalaninemia
- (NGS393) Maple Syrup Urine Disease
- (NGS396) Porphyria Disorders
- (NGS381) Mucopolysaccharidoses & Mucolipid Disorders
- (NGS313) Lysosomal Disease
- (NGS343) Peroxisomal Disease

## Cardiovascular

### Arrhythmias

- (NGS365) Hereditary Cardiac Arrhythmia
- (NGS366) Hereditary Ventricular Tachycardia Syndromes
- (NGS367) Arrhythmogenic Right Ventricular Dysplasia
- (NGS368) Long and Short QT Syndrome
- (NGS369) Brugada Syndrome

### Cardiomyopathies

- (NGS363) Comprehensive Cardiomyopathy + mtDNA
- (NGS364) Left Ventricular Noncompaction Cardiomyopathy Syndromes

### Congenital Heart Defects

- (NGS370) Congenital Heart Defects
- (NGS399) Heterotaxy Syndromes

### Connective Tissue Disorders

- (NGS377) Ehlers Danlos, Ehlers Danlos-like Syndromes, and Aneurysm Syndromes
- (NGS414) Noonan Syndrome
- (NGS378) Marfan and Marfan-like Syndromes

## Other Inherited Disorders

### Hearing Loss and Deafness

- (NGS458) Comprehensive Hearing Loss + mtDNA
- (NGS459) Waardenburg Syndrome
- (NGS461) Pendred Syndrome
- (NGS462) Perrault Syndrome
- (NGS463) Treacher-Collins Syndrome

### Vision and Ophthalmoplegia

- (NG464) Comprehensive Vision Loss & Eye Disorders + mtDNA
- (NGS352) Comprehensive Ophthalmoplegia Syndromes + mtDNA
- (NGS353) Cellular Energetics Ophthalmoplegia Syndromes + mtDNA
- (NGS354) Non-Mitochondrial Comprehensive Ophthalmoplegia Syndromes

### Multi-Sensory Disorders

- (NGS401) Stickler Syndrome
- (NGS402) Usher Syndrome
- (NGS460) Alport Syndrome

### Neurovascular

- (NGS429) Familial Hemiplegic Migraine + mtDNA
- (NGS430) Stroke + mtDNA
- (NGS452) Familial Hypercholesterolemia

### Nephrology

- (NGS379) Polycystic Kidney Disease
- (NGS392) Bartter/Gitelman Syndromes

### Neurocutaneous

- (NGS335) Neurofibromatosis
- (NGS397) Osteogenesis Imperfecta
- (NGS428) Tuberous Sclerosis

### Other

- (NGS319) Fever Syndromes
- (NGS371) Congenital Central Hypoventilation Syndromes
- (NGS404) Hypothyroidism
- (NGS466) Comprehensive Anemia



# Clinical Information Form

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Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

## Clinical (Check All That Apply)

- |   |   |  |                                 |
|---|---|--|---------------------------------|
| <b>Eye</b><br><input type="checkbox"/> Retinitis Pigmentosa<br><input type="checkbox"/> Optic Atrophy<br><input type="checkbox"/> Other | <b>Hearing</b><br><input type="checkbox"/> Sensorineural <input type="checkbox"/> Stickler <input type="checkbox"/> Usher | <b>Neuronal Migration</b><br><input type="checkbox"/> Meckel <input type="checkbox"/> Joubert <input type="checkbox"/> Other | <input type="checkbox"/> Stroke |
|---|---|--|---------------------------------|

- Cognitive/Neurobehavioral**  Intellectual Disability (ID)  Syndromic ID  Nonsyndromic ID  Autism  Dementia

- Movement Disorders**  Ataxia  Episodic Ataxia  Dystonia  Chorea/Athetosis  Parkinson Disease  L-Dopa Response

- |   |  |  |
|---|--|--|
| <b>Epilepsy</b><br><input type="checkbox"/> Myoclonic <input type="checkbox"/> Other<br><input type="checkbox"/> Absence <input type="checkbox"/> Tonic Clonic<br><input type="checkbox"/> Epileptic Encephalopathy | <b>Spasticity</b><br><input type="checkbox"/> Spastic Paraplegia <input type="checkbox"/> Other<br><input type="checkbox"/> Spastic Quadriplegia | <b>Connective Tissue &amp; Bone</b><br><input type="checkbox"/> Ehlers Danlos <input type="checkbox"/> Marfan <input type="checkbox"/> Aneurysms<br><input type="checkbox"/> Other |
|---|--|--|

- |   |  |
|---|--|
| <b>Neuromuscular</b><br><input type="checkbox"/> Distal <input type="checkbox"/> Proximal <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Contractures<br><input type="checkbox"/> Malignant Hyperthermia <input type="checkbox"/> Arthrogryposis <input type="checkbox"/> Rhabdomyolysis<br><input type="checkbox"/> Periodic Paralysis <input type="checkbox"/> Statin Use <input type="checkbox"/> Myasthenia | <b>Nerve/Anterior Horn Cell</b><br><input type="checkbox"/> Neurofibromas <input type="checkbox"/> Charcot-Marie-Tooth <input type="checkbox"/> Sensory<br><input type="checkbox"/> Autonomic <input type="checkbox"/> Pain <input type="checkbox"/> Motor <input type="checkbox"/> Nerve Conduction<br><input type="checkbox"/> Other |
|---|--|

- |   |   |  |  |
|---|---|--|--|
| <b>Cardiomyopathy</b><br><input type="checkbox"/> Dilated <input type="checkbox"/> Hypertrophic<br><input type="checkbox"/> Noncompaction | <b>Arrhythmias</b><br><input type="checkbox"/> Ventricular Tachycardia <input type="checkbox"/> Brugada<br><input type="checkbox"/> Long or Short QT <input type="checkbox"/> Conduction Defect | <b>Congenital Heart Defects</b><br><input type="checkbox"/> Heterotaxy<br><input type="checkbox"/> Other | <b>Endocrine</b><br><input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Other<br><input type="checkbox"/> Diabetes Mellitus |
|---|---|--|--|

## Imaging (Check All That Apply)

- |   |   |   |
|---|---|---|
| <b>Brain MRI</b><br><input type="checkbox"/> Leigh Disease<br><input type="checkbox"/> Basal Ganglia Calcification<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Cerebellar Atrophy<br><input type="checkbox"/> Abnormal Myelin (describe) | <b>EEG (Describe Findings)</b><br>_____ | <b>EMG/NVC (Describe Findings)</b><br>_____ |
|---|---|---|

## Laboratory

- |   |  |
|---|--|
| <b>Metabolic (Describe Findings)</b><br>_____ | <b>Genetic (Describe Findings)</b><br>_____  |
| <b>CPK</b> Maximum _____<br>Minimum _____     | <input type="checkbox"/> Chromosomal Microarray<br><input type="checkbox"/> Deletion/Insertion Testing<br><input type="checkbox"/> Other (comment) |

## Family History

- Ethnicity (please check)**
- |                                    |   |   |                                       |
|------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> Sephardic Jewish | <input type="checkbox"/> African American (or Black)          | <input type="checkbox"/> Asian        |
| <input type="checkbox"/> Hispanic  | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Native American (or American Indian) | <input type="checkbox"/> Other: _____ |
- |                                  |                                  |                         |
|----------------------------------|----------------------------------|-------------------------|
| <b>Affected Maternal Lineage</b> | <b>Affected Paternal Lineage</b> | <b>Siblings</b>         |
| Relationship to Proband          | Relationship to Proband          | Number (specify gender) |
| Symptoms                         | Symptoms                         | Healthy/Affected        |

**Additional Comments**  
\_\_\_\_\_  
\_\_\_\_\_



# STAT Test Request Form

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Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

## STAT Testing - Expedite Your Results

**IMPORTANT:** To request STAT Testing, STAT Testing Form must be **completed, signed and submitted** with test request form. Failure to do so will delay your order.

For an additional fee, the following tests are available for STAT Testing:

<b>Neurochemistry (NC) &amp; Metabolic (MET) Tests</b> 7 day TAT	<b>Molecular (MOL) Tests</b> 2 week TAT	<b>Next-Generation Sequencing (NGS) Panels</b> 2 week TAT
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*NOTE: MNG Laboratories will ensure any STAT orders meet the stated deadline, or the STAT fee will be waived.*

## Patient and Specimen Information

Patient Last Name	Patient First Name
Patient ID #	Date of Birth [MM/DD/YYYY]

## Test Code

*IMPORTANT: Enzymology, familial variants, and RNA tests NOT available as STAT*

Test Code: _____	Test Code: _____	Test Code: _____
Test Code: _____	Test Code: _____	Test Code: _____
Test Code: _____	Test Code: _____	Test Code: _____
Test Code: _____	Test Code: _____	Test Code: _____

## Billing Information (REQUIRED)

Self-Pay? <input type="checkbox"/> Yes    If yes, <b>MUST</b> include payer contact name & details below. Payment must be received in full prior to testing.		
Facility	Contact Name	
Billing Address		
City, State, Zip Code		
Phone	Fax	Email

### I HEREBY ACKNOWLEDGE (check all & sign below):

I acknowledge that the responsible billing party listed above will pay for the additional costs associated with ordering a STAT Test. I understand that failure to submit payment for STAT Testing will delay my order.

I consent that all requested STAT Tests listed above are either Neurochemistry tests, Metabolic tests, Molecular Tests or Next-Generation Sequencing Panels. I understand that all other tests are not available for STAT Testing and will not be ran as a STAT Test if requested.

**Signature of Responsible Billing Party (required):** \_\_\_\_\_



# Informed Consent for Genetic Testing

In compliance with New York State Civil Law: Section 79-L

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Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Please provide a copy of **completed** consent with sample and requisition. Failure to do so may delay testing.

When signed and dated, this written consent is written authorization to participate in genetic testing.

- Purpose of the Test:** My physician has explained the recommended testing: \_\_\_\_\_ (name of test or MNG test code), which is performed to help diagnose \_\_\_\_\_ (insert disease description).

I am aware that all documentation regarding this testing, including the description of the purpose, methodology, and disorders is freely available at [www.mnglabs.com/tests](http://www.mnglabs.com/tests) and has either been reviewed with me by my physician or I have read the documentation on my own. **Patient (or parent/guardian) initials:** \_\_\_\_\_

- Statement Regarding Test Result:** A positive test result is an indication that the individual has a genetic cause for the specific disease tested for. A negative result may/may not rule out a genetic disorder depending on clinical history and quality/type of specimen tested. The individual may wish to consider further independent testing, consult a personal physician or pursue genetic counseling.

- Level of Certainty:** Is test-specific and determined by the methods employed, patient's clinical history and sometimes by the nature of the patient's condition at time of sampling. There is always a small possibility of error or failure in sample analysis; this is true with complex testing in any laboratory. Inclusion of clinical data, such as medical history, family history, images as they relate to the disease or disorder, will decrease the level of uncertainty in an interpretation and are encouraged to be included when submitting samples for analysis. MNG Laboratories will keep personal information private in accordance with HIPAA laws.

**I consent to the retention of these documents by MNG Laboratories in their database.**

**Patient (or parent/guardian) Initials:** \_\_\_\_\_

- Disclosing Test Results:** The following categories of persons or organizations that test results may be released to include, but are not limited to: hospitals or laboratories involved in the patient's care, referring physician(s) and primary care providers, other physician groups (consultants, surgeons), insurance companies (as provided by the patient or referring physician for payment purposes), and other professionals involved in patient care that assist MNG Laboratories in carrying out treatment, payment, and operational activities. Results are kept confidential. Medical Neurogenetics complies with security and privacy statutes of the federal Health Information Portability and Accountability Act (HIPAA). If a patient chooses to specifically declare where results may be released (other than the referring institution and ordering physician), please provide these *in writing* to the Compliance Officer, MNG Laboratories ([quickresponse@mnglabs.com](mailto:quickresponse@mnglabs.com)).

- Consent to Retain Specimen:** The laboratory does not return any remaining sample to individuals or physicians unless requested. No clinical tests other than those authorized shall be performed on the sample. A request for additional testing must be made by my referring physician or other authorized healthcare professional and there will be an additional charge. If agreed by the patient, MNG Laboratories will retain the samples for longer periods for use in an anonymous fashion for research/development or for quality assurance processes.

**I consent to have my specimens retained after completion of initial testing (this consent may be withdrawn at any time and the laboratory will destroy any remaining sample).** **Patient (or parent/guardian) Initials:** \_\_\_\_\_

- Testing for Genetic Conditions can be Complex:** If warranted, obtain professional genetic counseling prior to giving consent to fully understand what the risks and benefits are to having the testing completed. I hereby consent to participate in testing described above. I understand that a biologic specimen will be obtained from me and/or members of my family. I understand that this biologic specimen will be used for the purpose of attempting to determine if I, or members of my family, are affected or are carriers of a particular disease or are at increased risk to someday be affected with this genetic disease.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Authorized Signature (Parent/Guardian)**

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name of Patient (please print clearly)

\_\_\_\_\_  
Name of Ordering MD (please print clearly)

\_\_\_\_\_  
Referring Facility (please print clearly)

\_\_\_\_\_  
**Signature of Ordering MD**

**Important: One signature from patient (or parent/guardian), authorized person, or physician is required to complete this form. New York requires signatures from patient (or parent/guardian) OR ordering physician to complete this form.**