



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]	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Specimen Type <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, MUST 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



Patient Name _____

DOB _____

Epilepsy

- (NGS412) Myoclonic Epilepsy

Movement Disorders

Ataxia / Episodic Ataxia

- | | |
|--|---|
| <input type="checkbox"/> (NGS324) Ataxia/Episodic Ataxia Disorders + mtDNA | <input type="checkbox"/> (NGS420) Ataxia/Episodic Ataxia Disorders + mtDNA + SCA & FRDA Repeat Expansions |
| <input type="checkbox"/> (NGS417) Ataxia/Episodic Ataxia Disorders + mtDNA + SCA & HTT Repeat Expansions | <input type="checkbox"/> (NGS431) Ataxia/Episodic Ataxia Disorders + mtDNA + SCA Repeat Expansions |

Dystonias

- | | |
|--|--|
| <input type="checkbox"/> (NGS358) Comprehensive Dystonia + mtDNA | <input type="checkbox"/> (NGS357) Parkinsons Disease/Parkinsonism |
| <input type="checkbox"/> (NGS409) Comprehensive Dystonia + mtDNA + HTT Repeat Expansions | <input type="checkbox"/> (NGS360) Basal Ganglia Calcification Dystonia |

Neuromuscular

Muscular Dystrophy / Myopathy

- | | |
|---|--|
| <input type="checkbox"/> (NGS330) Comprehensive Muscular Dystrophy/Myopathy + mtDNA | <input type="checkbox"/> (NGS413) Congenital Myopathies |
| <input type="checkbox"/> (NGS331) Congenital Myasthenic Syndromes | <input type="checkbox"/> (NGS424) Duchenne/Becker Muscular Dystrophy |
| <input type="checkbox"/> (NGS332) Hypokalemic & Hyperkalemic Periodic Paralysis | <input type="checkbox"/> (NGS333) Malignant Hyperthermia |

Neuropathies

- | | |
|---|--|
| <input type="checkbox"/> (NGS445) Comprehensive Neuropathies | <input type="checkbox"/> (NGS323) Amyotrophic Lateral Sclerosis |
| <input type="checkbox"/> (NGS346) Hereditary Sensory & Autonomic Neuropathy | <input type="checkbox"/> (NGS405) Amyotrophic Lateral Sclerosis + C9orf72 Repeat Expansion |
| <input type="checkbox"/> (NGS400) Pain Syndromes | <input type="checkbox"/> (NGS337) Spastic Paraplegia + mtDNA |
| <input type="checkbox"/> (NGS345) Charcot-Marie-Tooth Disease + mtDNA | |

Neurobehavioral

Intellectual Disability / Autism

- | | |
|--|--|
| <input type="checkbox"/> (NGS325) Comprehensive Intellectual Disability/Autism + mtDNA | <input type="checkbox"/> (NGS398) Macrocephaly & Overgrowth Syndrome |
| <input type="checkbox"/> (NGS349) Nonsyndromic Intellectual Disability | <input type="checkbox"/> (NGS425) Microcephaly |
| <input type="checkbox"/> (NGS350) Syndromic Intellectual Disability | |

Neurodegeneration

- | | |
|--|---|
| <input type="checkbox"/> (NGS376) Comprehensive Dementia | <input type="checkbox"/> (NGS356) Alzheimer Disease/Frontotemporal Dementia |
| <input type="checkbox"/> (NGS411) Comprehensive Dementia + C9orf72 & HTT Repeat Expansions | <input type="checkbox"/> (NGS380) Amyloid Related Disorders |

Brain Malformation Disorders

- | | |
|---|--|
| <input type="checkbox"/> (NGS372) Comprehensive Leukodystrophy/ Leukoencephalopathy + mtDNA | <input type="checkbox"/> (NGS387) Comprehensive Neuronal Migration Disorders + mtDNA |
|---|--|

Neurometabolic

- | | |
|---|--|
| <input type="checkbox"/> (NGS301) Comprehensive Cellular Energetics Defects + mtDNA | <input type="checkbox"/> (NGS396) Porphyrria Disorders |
| <input type="checkbox"/> (NGS302) Carbohydrate Metabolism Deficiency + mtDNA | <input type="checkbox"/> (NGS313) Lysosomal Disease |

Other Inherited Disorders

Vision and Ophthalmoplegia

- (NG464) Comprehensive Vision Loss & Eye Disorders + mtDNA
 (NGS352) Comprehensive Ophthalmoplegia Syndromes + mtDNA

Connective Tissue Disorders

- (NGS377) Ehlers Danlos, Ehlers Danlos-like Syndromes, and Aneurysm Syndromes

Multi-Sensory Disorders

- (NGS402) Usher Syndrome
 (NGS460) Alport Syndrome

Other

- (NGS429) Familial Hemiplegic Migraine + mtDNA
 (NGS430) Stroke + mtDNA
 (NGS379) Polycystic Kidney Disease
 (NGS392) Bartter/Gitelman Syndromes
 (NGS335) Neurofibromatosis
 (NGS428) Tuberous Sclerosis
 (NGS319) Fever Syndromes



Clinical Information Form

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Clinical (Check All That Apply)

Eye <input type="checkbox"/> Retinitis Pigmentosa <input type="checkbox"/> Optic Atrophy <input type="checkbox"/> Other	Hearing <input type="checkbox"/> Sensorineural <input type="checkbox"/> Stickler <input type="checkbox"/> Usher	Neuronal Migration <input type="checkbox"/> Meckel <input type="checkbox"/> Joubert <input type="checkbox"/> Other	<input type="checkbox"/> Stroke
Cognitive/Neurobehavioral <input type="checkbox"/> Intellectual Disability (ID) <input type="checkbox"/> Syndromic ID <input type="checkbox"/> Nonsyndromic ID <input type="checkbox"/> Autism <input type="checkbox"/> Dementia			
Movement Disorders <input type="checkbox"/> Ataxia <input type="checkbox"/> Episodic Ataxia <input type="checkbox"/> Dystonia <input type="checkbox"/> Chorea/Athetosis <input type="checkbox"/> Parkinson Disease <input type="checkbox"/> L-Dopa Response			
Epilepsy <input type="checkbox"/> Myoclonic <input type="checkbox"/> Other <input type="checkbox"/> Absence <input type="checkbox"/> Tonic Clonic <input type="checkbox"/> Epileptic Encephalopathy	Spasticity <input type="checkbox"/> Spastic Paraplegia <input type="checkbox"/> Other <input type="checkbox"/> Spastic Quadriplegia	Connective Tissue & Bone <input type="checkbox"/> Ehlers Danlos <input type="checkbox"/> Marfan <input type="checkbox"/> Aneurysms <input type="checkbox"/> Other	
Neuromuscular <input type="checkbox"/> Distal <input type="checkbox"/> Proximal <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Contractures <input type="checkbox"/> Malignant Hyperthermia <input type="checkbox"/> Arthrogyposis <input type="checkbox"/> Rhabdomyolysis <input type="checkbox"/> Periodic Paralysis <input type="checkbox"/> Statin Use <input type="checkbox"/> Myasthenia		Nerve/Anterior Horn Cell <input type="checkbox"/> Neurofibromas <input type="checkbox"/> Charcot-Marie-Tooth <input type="checkbox"/> Sensory <input type="checkbox"/> Autonomic <input type="checkbox"/> Pain <input type="checkbox"/> Motor <input type="checkbox"/> Nerve Conduction <input type="checkbox"/> Other	
Cardiomyopathy <input type="checkbox"/> Dilated <input type="checkbox"/> Hypertrophic <input type="checkbox"/> Noncompaction	Arrhythmias <input type="checkbox"/> Ventricular Tachycardia <input type="checkbox"/> Brugada <input type="checkbox"/> Long or Short QT <input type="checkbox"/> Conduction Defect	Congenital Heart Defects <input type="checkbox"/> Heterotaxy <input type="checkbox"/> Other	Endocrine <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Other <input type="checkbox"/> Diabetes Mellitus

Imaging (Check All That Apply)

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

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

Family History

Ethnicity (please check)

Caucasian Sephardic Jewish African American (or Black) Asian
 Hispanic Ashkenazi Jewish Native American (or American Indian) Other: _____

Affected Maternal Lineage	Affected Paternal Lineage	Siblings
Relationship to Proband	Relationship to Proband	Number (specify gender)
Symptoms	Symptoms	Healthy/Affected

Additional Comments



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.

1. **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 and has either been reviewed with me by my physician or I have read the documentation on my own. **Patient (or parent/guardian) initials:** _____

2. **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.

3. **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: _____

4. **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).

5. **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:** _____

6. **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.