



# 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><br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | <b>Specimen Type</b><br><input type="checkbox"/> Whole Blood<br><input type="checkbox"/> Buccal Swab | <input type="checkbox"/> CSF<br><input type="checkbox"/> Urine<br><input type="checkbox"/> Fibroblasts | <input type="checkbox"/> Plasma/Serum<br><input type="checkbox"/> DNA Tissue: _____<br><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<br>City, State, Zip Code       |                                | <input type="checkbox"/> Same as billing |  |
| Report Delivery<br><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



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

DOB \_\_\_\_\_

## Metabolic

### CSF

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> (MET01) Amino Acids <sup>†</sup>                            | <input type="checkbox"/> (NC04) Neurotransmitter Metabolites**<br>(5HIAA, HVA, 3OMD) [Includes Biomarkers for Pyridoxine Responsive Seizures]  | <input type="checkbox"/> (NC07) Sialic Acid [Disorders with Hypomyelination of Unknown Etiology/ Sialic Acid Storage Disorders] |
| <input type="checkbox"/> (MET07) Lactate   | <input type="checkbox"/> (NC05) Pyridoxal 5'-phosphate<br>[Pyridox[am]ine Phosphateoxidase Deficiency + CNS Pyridoxal 5'-phosphate Deficiency] | <input type="checkbox"/> (NC08) Alpha-Amino adipic Semialdehyde [Pyridoxine-Responsive Seizures]                                |
| <input type="checkbox"/> (MET11) Pyruvate*   | <input type="checkbox"/> (NC06) Succinyladenosine<br>[Adenylosuccinate Lyase Deficiency]   | <input type="checkbox"/> (NC10) Glucose [Glucose Transporter Deficiency]  |
| <input type="checkbox"/> (NC01) 5-Methyltetrahydrofolate                             |  | <input type="checkbox"/> (NC15) Sepiapterin & Dihydrobiopterin**  |
| <input type="checkbox"/> (NC02) Neopterin [Marker for CNS Immune System Stimulation] |  |   |
| <input type="checkbox"/> (NC03) Neopterin/Tetrahydrobiopterin **                     |  |   |

### Blood & Muscle

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> (MET02) Amino Acids (Plasma) <sup>†</sup> | <input type="checkbox"/> (MET12) Thymidine/Deoxyuridine Analytes (Plasma) | <input type="checkbox"/> (MET29) 3-O-Methyldopa (Plasma)<br>[Specific Marker for Aromatic L-Amino Acid Decarboxylase Deficiency] |
| <input type="checkbox"/> (MET04) Coenzyme Q10 Level (Leukocytes)   | <input type="checkbox"/> (MET23) Creatine & Guanidinoacetate (Plasma)     |  |
| <input type="checkbox"/> (MET05) Coenzyme Q10 Level (Muscle)       |   |  |

### Urine

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> (MET03) Amino Acids <sup>†</sup> | <input type="checkbox"/> (MET19) Creatine & Guanidinoacetate | <input type="checkbox"/> (MET20) Alpha Amino adipic Semialdehyde [Urine; for Pyridoxine-Responsive Seizures] |
|---|--|--|

## Enzymology

### Blood

- |   |  |
|---|--|
| <input type="checkbox"/> (ENZ01) Aromatic L-amino Acid Decarboxylase Enzyme Analysis (Plasma) - <b>STAT Not Available</b> | <input type="checkbox"/> (ENZ06) Thymidine Phosphorylase Enzyme Analysis (Blood) - <b>STAT Not Available</b> |
|---|--|

<sup>†</sup> Denotes testing performed at LabCorp, Burlington, NC - **STAT Not Available**

\* Denotes testing requires deproteinization

\*\* Denotes sample must be collected in tube #3 from supplied kit, Neopterin may be ordered if CSF collection kit not available.

++ Denotes to collect from first drops of lumbar puncture into single sterile tube. Do not aliquot from a pooled sample.



# Clinical Information Form

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

## Clinical (Check All That Apply)

- |            |   |                |   |                           |   |                                 |
|------------|---|----------------|---|---------------------------|---|---------------------------------|
| <b>Eye</b> | <input type="checkbox"/> Retinitis Pigmentosa<br><input type="checkbox"/> Optic Atrophy<br><input type="checkbox"/> Other | <b>Hearing</b> | <input type="checkbox"/> Sensorineural <input type="checkbox"/> Stickler <input type="checkbox"/> Usher | <b>Neuronal Migration</b> | <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> | <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> | <input type="checkbox"/> Spastic Paraplegia <input type="checkbox"/> Other<br><input type="checkbox"/> Spastic Quadriplegia | <b>Connective Tissue &amp; Bone</b> | <input type="checkbox"/> Ehlers Danlos <input type="checkbox"/> Marfan <input type="checkbox"/> Aneurysms<br><input type="checkbox"/> Other |
|-----------------|--|-------------------|---|-------------------------------------|---|

- |                      |  |                                 |   |
|----------------------|--|---------------------------------|---|
| <b>Neuromuscular</b> | <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"/> Arthrogyposis <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> | <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> | <input type="checkbox"/> Dilated <input type="checkbox"/> Hypertrophic<br><input type="checkbox"/> Noncompaction | <b>Arrhythmias</b> | <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> | <input type="checkbox"/> Heterotaxy<br><input type="checkbox"/> Other | <b>Endocrine</b> | <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Other<br><input type="checkbox"/> Diabetes Mellitus |
|-----------------------|--|--------------------|---|---------------------------------|---|------------------|--|

## Imaging (Check All That Apply)

- |   |                                |                                    |
|---|--------------------------------|------------------------------------|
| <b>Brain MRI</b>  | <b>EEG (Describe Findings)</b> | <b>EMG/NVC (Describe Findings)</b> |
| <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) |                                |                                    |

## Laboratory

- |                                      |  |
|--------------------------------------|--|
| <b>Metabolic (Describe Findings)</b> | <b>Genetic (Describe Findings)</b>   |
| CPK 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)**
- Caucasian  Sephardic Jewish  African American (or Black)  Asian  
 Hispanic  Ashkenazi Jewish  Native American (or American Indian)  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><br>7 day TAT | <b>Molecular (MOL) Tests</b><br>2 week TAT | <b>Next-Generation Sequencing (NGS) Panels</b><br>2 week TAT |
|---|--|--|

*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):** \_\_\_\_\_