EMORY GENETICS LABORATORY

GENERAL TEST REQUISITION FORM

2165 North Decatur Road Decatur, Georgia 30033
Phone: 855-831-7447 | 404-778-8499
Fax: 404-778-8559
http://geneticslab.emory.edu

PATIENT INFORMATION

Last Name _____

First Name _____ **MI**____

Parent name (if pt is a minor)/Spouse_____

Pt. ID/Med Rec# _____

DOB _____/_____/_____ (MM/DD/YYYY)

Gender ☐ Male ☐ Female ☐ Unknown ☐ Ambiguous

Ethnicity of pt. (check all that apply)

☐ African-American ☐ Asian

☐ Caucasian/NW European ☐ E. Indian ☐ Hispanic ☐ Jewish-Ashkenazi

☐ Jewish-Sephardic ☐ Mediterranean ☐ Native American

☐ Native Hawaiian/Other Pacific Islander ☐ Other _____

Address _____

_____

City _____ **State** _____ **Zip** _____

Preferred Phone (_____) _____ - _____

Secondary Phone (_____) _____ - _____

ENTITY ORDERING TEST (Fax # Required to Receive Report)

☐ **Physician**

Name_____

NPI _____

Phone (_____) _____ - _____**Fax** (_____) _____ - _____

Email _____

☐ **Laboratory/Institution**

Name_____

Address _____

Address 2: _____

City _____ **State** _____ **Zip** _____

Phone (_____) _____ - _____**Fax** (_____) _____ - _____

Email _____

DUPLICATE REPORTS TO (Fax # Required to Receive Report)

☐ **Genetic Counselor**

Name _____

Phone (_____) _____ - _____**Fax** (_____) _____ - _____

Email_____

☐ **Other**

Name_____

Phone (_____) _____ - _____**Fax** (_____) _____ - _____

Email _____

BILLING INFORMATION *Required*

ICD9 Codes:

Please complete billing information on page 2 of this form.

SPECIMEN INFORMATION

Date Collected _____ / _____ / _____ (MM/DD/YYYY)

Time _____ : _____ ☐ AM ☐ PM

SAMPLE TYPE

☐ Whole Blood ☐ Saliva ☐ DNA ☐ Muscle Biopsy ☐ Skin Biopsy ☐ DBS

☐ Serum ☐ Urine ☐ Plasma, Hep ☐ Plasma, EDTA ☐ Plasma, Other

☐ Leukocyte Pellet ☐ CSF ☐ Cult Fibroblast ☐ PUBS ☐ Other _____

PRENATAL SAMPLE TYPE

☐ Amniotic Fluid ☐ Cultured Amniotic Fluid ☐ POC

☐ Chorionic Villus ☐ Cultured Chorionic Villus ☐ DNA From _____

CLINICAL INFORMATION *REQUIRED*

Clinical findings/family history/test results (attach copies if appropriate)

Indication ☐ Diagnostic ☐ Carrier

Is patient/spouse/family member pregnant?

☐ No ☐ Yes **Check if relevant** ☐ Egg donor ☐ Sperm donor

LMP_____ **EDD**_____

Genotypes

Proband _____

Mother _____

Father _____

Diet

☐ Formula ☐ MCT Oil

☐ Breast Milk ☐ Hyperal

☐ Special _____

Medications

☐ Anticonvulsants ☐ Antidepressants ☐ Antibiotics ☐ HAF/TPN

☐ Carnitine ☐ Oral Contraceptives ☐ Other _____

Has Patient had any of the following?

☐ Transfusion ☐ Bone Marrow Transplant

FOR LAB USE ONLY

Rec/d_____/_____/_____ **Unboxed By** _____

Sender_____

TEMP	SPECIMEN	COLOR	# TUBES		COMP.	INCOMP.
R C F				**PT. DATA**	[ ]	[ ]
R C F				**TEST DATA**	[ ]	[ ]
R C F				**PHYSICIAN DATA**	[ ]	[ ]
R C F				**BILLING DATA**	[ ]	[ ]

BILLING

[ ] Facility Bill Acct # _____

[ ] Insurance Bill

[ ] Self-Pay

Hold Billing _____

QC _____

Reflex _____

Specimen _____

Accessioned by: Labeled by: Pickup:

INFORMATION FOR HEALTH CARE PROVIDERS AND PATIENTS

Emory Genetics Laboratory retains patient samples indefinitely for validation, educational purposes and/or research. For molecular cytogenetic and some molecular genetic tests, submitted clinical information and test results are also included in HIPAA-compliant, de-identified public databases as part of the National Institute of Health's effort to improve diagnostic testing and our understanding of the relationships between genetic changes and clinical symptoms (for information about the molecular cytogenetic database, visit the consortium website at https://www.iscaconsortium.org/ and for information about the molecular genetic database refer to the individual test descriptions). Confidentiality of each sample is maintained. Patients may request to withdraw consent for the storage of their sample and/or use of the data by: 1) calling the laboratory at 1-855-831-7447 and asking to speak with a laboratory genetic counselor or 2) visiting our website at http://www.geneticslab.emory.edu/opt-out.

[ ] Refusal for inclusion in these efforts may be indicated by checking this box. (If the box is not checked the data will be anonymized and used.)

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Submit this completed payment options form with the specimen. Testing is not initiated until billing information is received. Billing policy information is available at http://geneticslab.emory.edu/billing.

PAYMENT OPTIONS (please select one of the following options)

1 - ☐ INSTITUTION

*For new clients, to establish an institutional account, you must complete an Institutional Account Request Form **prior** to submitting an order. The form can be downloaded at http://geneticslab.emory.edu/billing. For any questions or to confirm whether you have an account or what your account number is, please contact our billing office at 404-778-8580 or by email at eglbilling@emory.edu.*

Institution _____ Account # _____

The following information is not required if account number is provided above:

Contact Name _____ Email _____

Billing Address _____

City _____ State _____ Zip _____

Phone_____ Fax _____

EGL Billing Label
Please call to request labels

2 - ☐ SELF PAY

☐ Cashier Check ☐ Visa ☐ MasterCard ☐ Discover

Amount $_____ (include discount if applicable)

Credit Card # _____ Expiration Date _____/_____

Cardholder Billing Address _____

City _____ State _____ Zip _____

Cardholder Phone _____

Required for credit card payments

_____
Cardholder Printed Name as it Appears on Card

_____
Cardholder Signature

3 - ☐ INSURANCE (Also includes Wellcare, Amerigroup, Peachstate for GA Residents and Medicare). EGL does not accept Georgia Medicaid or any out of state Medicaid.

*A **legible** front and back copy of insurance card and insurance authorization must be included. A completed Advance Beneficiary Notice of coverage (ABN) is required for Medicare patients.*

ICD9 Diagnosis Code(s) *Required _____

PRIMARY Policyholder Name _____ DOB ____/____/_____

Relationship to the Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____ Gender ☐ Male ☐ Female

Insurance Co. Name _____ Policy No. _____ Group No. _____

Address _____

City _____ State _____ Zip _____

Phone _____ Authorization Number (Copy of authorization letter also required) _____

SECONDARY Policyholder Name _____ DOB ____/____/_____

Relationship to the Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____ Gender ☐ Male ☐ Female

Insurance Co. Name _____ Policy No. _____ Group No. _____

Address _____

City _____ State _____ Zip _____

Phone _____ Authorization Number (Copy of authorization letter also required) _____

Authorization to assign benefits, accept financial responsibility, and disclose health records

If I am entitled to benefits under the Medicare program, or any insurance policy or other health benefit plan, in consideration for services provided to me by EGL, I assign, transfer and convey the benefits payable under such program, policy or plan for such services to EGL. I authorize payment of benefits directly to EGL, with such benefits applied to my bill. I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me and I agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, not pre-certified or not preauthorized by my insurance plan. I understand that EGL is permitted to disclose my health information for purposes of payment of bills (if I filled out section 3 above), my continued care or treatment, and healthcare operations.

Signature of Patient, Parent, or Guardian: (Required)_____ **Date** _____/_____/_____

INTERNATIONAL SAMPLES

Payment in full must be made before samples will be processed. Prepaid samples may receive a discount when required payment is received with the sample. Please visit our website for more information: http:geneticslab.emory.edu/billing/international. Payment by credit card can be indicated under option 2 above. Banker's checks or money orders must be made payable to Emory Genetics Laboratory. Please contact the EGL billing office for further arrangements or when you make an electronic fund payment at 404-778-8580 or eglbilling@emory.edu.

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Note: Call to discuss prenatal molecular genetic testing with the laboratory genetic counselor PRIOR to sending a prenatal sample. 5 ml maternal blood in an EDTA (purple top) tube MUST accompany a prenatal specimen.

BIOCHEMICAL GENETIC TESTING

Order	Code	Congenital Disorders of Glycosylation - Biochemical
	BCDGP	N-glycan and Transferrin Panel
	OS	Oligosaccharide and Glycan Screening
	BCDGS	CDG Transferrin
	BNGLY	N-glycan Analysis for CDGs
	BOGLY	CDG: O-glycan only
Order	**Code**	**Galactosemia (Comprehensive)**
	GS	Galactosemia Panel (GALT activity and Gal-1-P) *If enzyme testing comes back abnormal and you would like to automatically reflex to GALT full gene sequencing, please select test code SG below.*
	GR	Galactosemia Carrier Panel (GALT Activity) *If enzyme testing comes back abnormal and you would like to automatically reflex to GALT full gene sequencing, please select test code SG below.*
	GL	Galactitol
	GT	Galactosemia: GALT Enzyme Activity
	GP	Galactose-1-Phosphate Profile
[ ] Seq [ ] Del/Dup	SG DGALT	Galactosemia - *GALT* gene
Order	**Code**	**Lysosomal Storage Disorders - Enzyme**
	LS	Lysosomal Enzyme Panel (13 enzymes), Blood
Order	**Code**	**Lysosomal Storage Disorders - Screening and Monitoring**
	BLSDS	Lysosomal Storage Disease (LSD) Screen, Urine (GA, OS)
	GA	Mucopolysaccharide (MPS) Screen, Urine
	BM	Gaucher Biomarker Panel (ACE, CHITO, TRAP)
Order	**Code**	**Metabolic and Analyte Studies**
	MW	Genetic Metabolic Panel (AA, AR, CN, OA)
	AR	Acylcarnitine Profile
	ED	Amino Acids Analysis, CSF
	AA	Amino Acids Analysis, Plasma
	UA	Amino Acids Analysis, Urine
	BCAHP	CAH Profile, Dried Blood Spot
	CN	Carnitine Concentration Profile, Plasma
	UC	Carnitine Concentration Profile, Urine
	BCQLC	Coenzyme Q10, Leukocytes
	CQ	Coenzyme Q10, Plasma
	BHOBS	Homocysteine, Total, Dried Blood Spot
	HO	Homocysteine, Total, Plasma
	MQ	Methylmalonic Acid Quantitation, Plasma
	BMMAU	Methylmalonic Acid Quantitation, Urine
	BMMAD	MMA & MCA, Dried Blood Spot
	BMSUD	MSUD: Allo-isoleucine & BCAA, Dried Blood Spot
	BNBSF	NBS Follow-up: Elevated C3 (AA, AR, CN, OA, HO)
	OA	Organic Acids Quantitative Analysis
	OT	Orotic Acid Assay

Order	Code	Metabolic and Analyte Studies
	ZF	Pyruvic Acid, Blood
	ZE	Pyruvic Acid, CSF
	BSLOS	Smith-Lemli-Opitz Screen by MSMS
Order	**Code**	**Other Enzyme Assays**
	BX	Biotinidase Enzyme Acitivity
	ZU	Maple Syrup Urine Disease, BCKD Enzyme Activity, fibroblast
	BC	Maple Syrup Urine Disease, BCKD Enzyme Activity, Lymphoblast
Order	**Code**	**STAT Biochemical Testing**
	BARST	Acylcarnitine Profile (STAT) Must contact laboratory before receipt of sample.
	BAAST	Amino Acids Analysis, Plasma (STAT) Must contact laboratory before receipt of sample.
	BOAST	Organic Acids Quantative Analysis (STAT) Must contact laboratory before receipt of sample.

CYTOGENETIC TESTING

Order	Code	Chromosomal Microarray
	VA	EmArray Cyto
	CMSNP	CytoScan SNP Array
	CMPOC	CytoScan SNP Array POC (MCC not included but recommended- also order below if requested)
	CMCCS	Maternal Cell Contamination (MCC)
Order	**Code**	**Chromosome Analysis**
	CA	Peripheral Blood, Age: 6 months and above
	CB	Peripheral Blood, Age: less than 6 months
	MM	Peripheral Blood, Mosaicism study
	AD	Amniotic Fluid (includes AFP with reflex to ACHE)
	CV	Chorionic Villi
	CP	Fetal Blood (PUBS)
	CO	Products of Conception (EmArray Cyto POC recommended as first tier)
	FS	Targeted Family Member Study (attach report)
Order	**Code**	**FISH STAT**
	RS	Prenatal FISH - Aneuploidy (13,18, 21, X&Y)
	CFXYS	X and Y (ambiguous genitalia)
	CF22S	22q11 microdeletion (DiGeorge, VCF)
	CF13S	Trisomy 13
	CF18S	Trisomy 18
	CF21S	Trisomy 21
Order	**Code**	**FISH Standard**
	PA	FISH Analysis with Culture (Also indicate probe below, if probe not listed, check other)
	FI	FISH Analysis without Culture (Also indicate probe below, if probe not listed, check other)
		Array Confirmation/Family Studies Custom Other: _____
		Wolf-Hirschhorn (4p-)
		Cri-du-Chat (5p-)

Highlighted test names indicate panel tests.

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Note: Call to discuss prenatal molecular genetic testing with the laboratory genetic counselor PRIOR to sending a prenatal sample. 5 ml maternal blood in an EDTA (purple top) tube MUST accompany a prenatal specimen.

Order	Code	FISH Standard
		Williams (7q11.2 del)
		Prader-Willi/Angelman (Order after DNA methylation)
		Smith-Magenis (17p11.2 del)
		Miller-Dieker, lissencephaly (17p13)
		17q21 Microdeletion Syndrome
		22q11.2 deletion, DiGeorge/VCF (reflex test if heart defect on fetal u/s)
	TL	Telomere Panel
Order	**Code**	**Other Cyto Tests**
	TC	Tissue Culture
		MOLECULAR GENETIC TESTING
Order	**Code**	**Ashkenazi Jewish Disease Screening**
	AJ	Ashkenazi Jewish Carrier Screening Panel (DNA & Tay-Sachs Enzyme) *This testing is being updated and not currently available for testing until July 2013.*
	MAJSP	Ashkenazi Jewish Carrier Screening Panel: DNA Only *This testing is being updated and not currently available for testing until July 2013.*
Order	**Code**	**Cardiac Disorders**
	MCAR1	Cardiomyopathy Panel
[ ] Seq [ ] Del/Dup	SCACN DCACN	*CACNA1C*-Related Disorders - *CACNA1C* gene
[ ] Seq [ ] Del/Dup	DK KP	Isolated Nonsyndromic Congenital Heart Disease - *NKX2-5* gene
[ ] Seq [ ] Del/Dup	SMAP1 DMAP1	*MAP2K1*-Related Disorders - *MAP2K1* gene
[ ] Seq [ ] Del/Dup	SRYR2 DRYR2	*RYR2*-Related Disorders - *RYR2* gene
[ ] Seq [ ] Del/Dup	STPM1 DTPM1	*TPM1*-Related Disorders - *TPM1* gene
	STTNX	*TTN*-Related Disorders - *TTN* gene
Order	**Code**	**Ciliopathies**
	MCIL1	Ciliopathies Panel
Order	**Code**	**Congenital Abnormality Syndromes**
	MNOO1	Noonan Syndrome & Related Disorders Panel
	CC061	1q21.1 Del/Dup Analysis
[ ] Seq [ ] Del/Dup	SBLM1 DBLM1	Bloom Syndrome - *BLM* gene
[ ] Seq [ ] Del/Dup	SBRAF DBRAF	*BRAF*-Related Disorders - *BRAF* seq
[ ] Seq [ ] Del/Dup	SMAP2 DMAP2	CFC syndrome, *MAP2K2*-Related - *MAP2K2* gene
[ ] Seq [ ] Del/Dup	UH DCHD7	CHARGE Syndrome - *CHD7* Gene
[ ] Seq [ ] Del/Dup	SHRAS DHRAS	Costello Syndrome - *HRAS* gene

Order	Code	Congenital Abnormality Syndromes
[ ] Seq [ ] Del/Dup	SKDM6 DKDM6	Kabuki Syndrome - *KDM6A* Full Gene Sequencing
[ ] Seq [ ] Del/Dup	SMLL2 DMLL2	Kabuki Syndrome - *KMT2D* gene
	MKABP	Kabuki Syndrome Panel - *KMT2D* and *KDM6A* seq and del/dup
[ ] Seq [ ] Del/Dup	ZG DKRAS	*KRAS*-Related Disorders - *KRAS* gene
	SSPRE	Legius Syndrome: *SPRED1* gene sequencing
[ ] Seq [ ] Del/Dup	SNRAS DNRAS	Noonan Syndrome - *NRAS* gene
[ ] Seq [ ] Del/Dup	UG DPTPN	Noonan Syndrome - *PTPN11* gene
[ ] Seq [ ] Del/Dup	SSOS1 DSOS1	Noonan Syndrome - *SOS1* gene
[ ] Seq [ ] Del/Dup	SRAF1 DRAF1	Noonan Syndrome: *RAF1* gene
[ ] Seq [ ] Del/Dup	SSHOC DSHOC	Noonan-Like Syndrome with Loose Anagen Hair - *SHOC2* gene
[ ] Seq [ ] Del/Dup	SCREB DCREB	Rubinstein-Taybi Syndrome - *CREBBP* gene
	SEP30	Rubinstein-Taybi Syndrome - *EP300* gene sequencing
[ ] Seq [ ] Del/Dup	SDHCR DDHCR	Smith-Lemli-Opitz Syndrome- *DHCR7* gene
[ ] Del/Dup [ ] Seq	DRAI1 SRAI1	Smith-Magenis Syndrome- *RAI1* gene
[ ] Seq [ ] Del/Dup	SNSD1 DNSD1	Sotos Syndrome - *NSD1* gene
	XM060	TAR panel
	MS061	TAR Syndrome - *RBM8A* gene sequencing
Order	**Code**	**Cornelia de Lange**
[ ] Seq [ ] Del/Dup	SNIPB DNIPB	Cornelia de Lange Syndrome- *NIPBL* gene
[ ] Seq [ ] Del/Dup	SSMC1 DSMC1	Cornelia de Lange Syndrome- *SMC1A* gene
Order	**Code**	**Cystic Fibrosis**
[ ] Seq [ ] Del/Dup	JK JL	Cystic Fibrosis - *CFTR* gene
	CF	Cystic Fibrosis Common Mutation Panel
Order	**Code**	**Eye Disorders**
	MM030	Eye Disorders Panel
[ ] Seq [ ] Del/Dup	SBEST DBEST	*BEST1*-Related Disorders - *BEST1* gene
	MM032	Achromatopsia/Cone/Cone-Rod Dystrophy Panel
[ ] Seq [ ] Del/Dup	AF KN	Autosomal Dominant Optic Atrophy and Cataract - *OPA3* gene
[ ] Seq [ ] Del/Dup	DL KO	Autosomal Dominant Optic Atrophy, Kjer Type - *OPA1* gene

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Order	Code	Eye Disorders
	MM033	Central Areolar Choroidal Dystrophy/Chorioretinal Atrophy Panel
[ ] Seq [ ] Del/Dup	SCHMX DCHMX	Choroideremia - *CHM* gene
	MM034	Congenital Stationary Night Blindness Panel
	SHPS1	Hermansky-Pudlak Syndrome - *HPS1* gene sequencing
[ ] Seq [ ] Del/Dup	SHPS4 DHPS4	Hermansky-Pudlak Syndrome - *HPS4* gene
	MM035	Leber Congenital Amaurosis Panel
	QC	Leber Hereditary Optic Neuropathy (LHON)
	MM036	Macular/ Pattern Dystrophies Panel
	MM037	Optic Atrophy Panel
	MM039	Other Eye Disorders Panel
[ ] Seq [ ] Del/Dup	SPAX6 DPAX6	*PAX6*-Related Disorders - *PAX6* gene
	MM031	Photoreceptor Dystrophy/Degeneration
	MM038	Retinitis Pigmentosa Panel
[ ] Seq [ ] Del/Dup	SRB1X DRB1X	Retinoblastoma - *RB1* gene
[ ] Seq [ ] Del/Dup	SRP20 DRP20	*RP2*-Related X-Linked Retinitis Pigmentosa - *RP2* gene
	SDHDD	RP59 - *DHDDS* gene sequencing
[ ] Seq [ ] Del/Dup	SRPGR DRPGR	*RPGR*-Related X-Linked Retinitis Pigmentosa - *RPGR* gene sequencing
Order	**Code**	**Growth Disorders**
	XM010	Short Stature Panel - Comprehensive
	XM011	Short Stature Panel - SNP Array, NGS and Del/Dup
	MM011	Short Stature Panel - Russell-Silver Panel, NGS and Del/Dup
	MM012	Short Stature Panel - NGS & Del/Dup
	BW	Beckwith-Wiedemann Panel: *H19 & Lit1* Methylation
	ZP	Beckwith-Wiedemann: *H19* Methylation
	BL	Beckwith-Wiedemann: *Lit1* Methylation
	NZ	Russell-Silver Panel - *H19* Methylation & UPD7
	NM	Russell-Silver Syndrome: UPD7
	RT	Russell-Silver: *H19* Methylation
	SSHOX	*SHOX*-Related Haploinsufficiency Disorders - *SHOX* gene sequencing
Order	**Code**	**Hearing Loss**
	HL	Hearing Loss Panel - Cx26 & 30 Sequencing, Cx30 Common Deletion, Mitochiondrial HL
[ ] Seq [ ] Del/Dup	SX PI	Hearing Loss: *GJB2* & *GJB6* - gene panel *(Sequencing includes Cx30 common deletion)*
	OZ	Hearing Loss - *GJB2* sequencing
	FL	Hearing Loss - *GJB6* Seq *(Includes Cx30 common deletion)*

Order	Code	Hearing Loss
	QJ	Mitochondrial Hearing Loss Common Mutations
	AT	Alpha-Thalassemia: *HBA1* and *HBA2* deletion analysis
	HS	Sickle Cell Disease - HbS/HbC Mutations
Order	**Code**	**Infertility**
	MG	Female Infertility Panel (Chromosomes, *FMR1* - Related POF)
	XM050	Male Infertility Panel (Chromosomes, CF common mutation panel, Y-Microdeletions)
	MFMR1	Premature Ovarian Insufficiency - *FMR1* CGG Repeat Analysis
	YD	Y-Chromosome Microdeletions for Infertility
Order	**Code**	**Methylation Studies**
	OO	Chromosome 14 Uniparental Disomy
	TU	Chromosome 6 Uniparental Disomy
	PW	Prader Willi/Angelman *(order before FISH)*
Order	**Code**	**Mitochondrial Disease**
	QB	CPEO
	ZO	Kearns-Sayre Syndrome
	QD	Leigh Disease
	QA	MELAS
	QH	MERRF
	ML	Mitochondrial Southern Blot for Deletions
	ZN	Pearson Marrow-Pancreas Syndrome
	QK	Retinitis Pigmentosa and Ataxia (NARP)
	JD	Mitochondrial Full Genome Sequencing (*one of above tests recommended first, if indicated*)
Order	**Code**	**Movement Disorders**
	SSETX	Ataxia with Oculomotor Apraxia Type 2 - *SETX* gene sequencing
	FJ	Fragile X-Associated Tremor/Ataxia (FXTAS) - CGG Repeat Analysis
	HT	Huntington Disease - CAG Repeat Analysis (Requires Consent)
	SAT7B	Wilson Disease: *ATP7B* gene sequencing
Order	**Code**	**Seizure Disorders**
	MEPI1	Epilepsy and Seizure Disorders Panel
	SGABR	Childhood Absence Epilepsy - *GABRB3* gene
[ ] Seq [ ] Del/Dup	SPNKP DPNKP	Early Infantile Epileptic Encephalopathy Type 10 - *PNKP* gene
[ ] Seq [ ] Del/Dup	SSLC2 DSLC2	Glucose Transporter Type 1 Deficiency Syndrome- *SLC2A1* gene
[ ] Seq [ ] Del/Dup	SRELN DRELN	Lissencephaly 2 - *RELN* gene
Order	**Code**	**Sex Determination**
	DY	Y-Chromosome Detection

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Order	Code	Skin Disorders
	SMSMO	*MSMO1*-Related Psoriasiform Dermatitis - *MSMO1* gene sequencing
[ ] Seq [ ] Del/Dup	SZMPS DZMPS	*ZMPSTE24*-Related Disorders - *ZMPSTE24* gene
Order	**Code**	**Twin Zygosity**
	ZT	Twin Zygosity Testing
Order	**Code**	**Known Mutation Analysis**
	KM	Known Mutation Testing *(Please indicate mutation/s information on page 1)*
	DKMDD	Known Mutation Testing for Del/Dup *(Please indicate mutation/s information on page 1)*
		OTHER
Order	**Code**	**Other**
[ ] Seq [ ] Del/Dup	SFOXG DFOXG	Congenital Variant Rett Syndrome- *FOXG1* gene
		OTHER TESTS
Order	**Code**	
		Other Test *(Please Specify):* _____

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