

FSHD1 and FSHD2 REQUISITION

FOR CLIENT USE ONLY: Requisition Date: _____ Completed By: _____ Acqn# _____	FOR UIDL USE ONLY: UIDL Path # _____ UIDL MRN# _____
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PART A - PATIENT INFORMATION - <i>Required</i>	PART B - PROVIDER INFORMATION - <i>Required</i>
Patient Name: _____	Referring Institution: _____
Street: _____	Street: _____
City: _____ St: _____ Zip: _____	City: _____ St: _____ Zip: _____
Phone: () _____	Phone: _____ Fax: _____
Date of Birth: _____	Referring Physician: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	

SPECIMEN INFORMATION
BLOOD SAMPLE SUBMITTED:

Liquid DNA specimens are not acceptable for this assay unless only sent for methylation studies or SMCHD1 sequencing. DNA sample at least 50 µl, concentration 0.25 µg/µl.

_____ 6 ml pink top (K2-EDTA) and _____ 6 ml pink top (K2-EDTA) and _____ 3 ml lavender top (EDTA)

Required ICD-9 codes: 1. _____ 2. _____ 3. _____ 4. _____

TISSUE SOURCE/SITE: BLOOD

DATE OF COLLECTION: _____

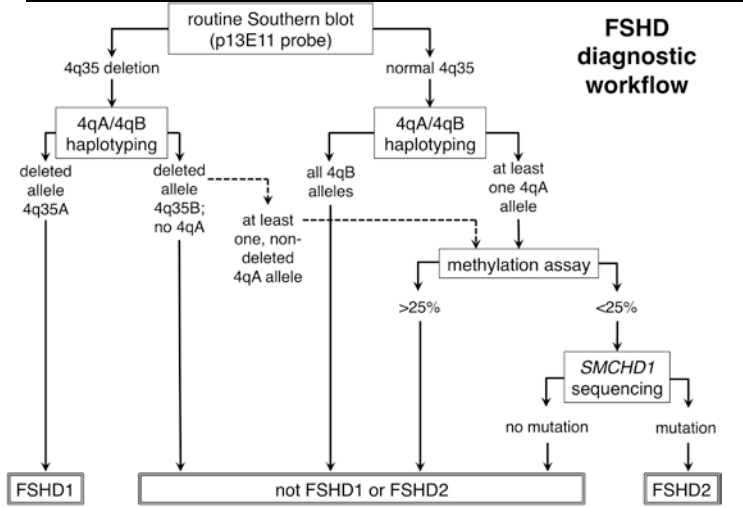
Physician signature _____

ATTACH PERTINENT CLINICAL HISTORY

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.

SEND BILL TO:
 Referring Institution Patient's Insurance
PRE AUTHORIZATION REQUIRED _____

Primary Insurance Coverage Information
Insured by: _____
Claims Address: _____
City: _____ ST: _____ ZIP: _____
Policy/ID #: _____
Group #: _____
Name of Subscriber: _____ DOB: _____
Relationship to Patient: _____



FSHD TESTING REQUESTED:

Full Test Panel, see workflow diagram (CPT 81404)

Individual Components, check all that apply

routine Southern blot (CPT 81404)

4qA/4qB haplotyping (CPT 81404)

methylation (CPT 81479)

SMCHD1 Sequencing (CPT 81479)

- By requesting this test, the ordering physician assumes responsibility for providing the patient with associated guidance and genetic counseling regarding the test results. Does the physician assume this responsibility?
Yes _____ No _____
- Has your patient had prior testing for FSHD?
Yes - Provide lab and date: _____
No or unknown _____
- Does your patient have a 4q35 deletion?
Yes. Size of deleted 4q35 EcoRI fragment, if known: _____
No or unknown _____
- Has your patient undergone 4qA/4qB allele testing?
Yes _____ No or unknown _____
- Does your patient have one or more 4q35A alleles?
Yes _____ No or unknown _____
- Does your patient have a family history of FSHD1 that has been confirmed by molecular genetic testing?
Yes. Size of deleted 4q35 EcoRI fragment, if known: _____
No or unknown _____
- Does your patient have a family history of FSHD2 that has been confirmed by molecular genetic testing?
Yes. SMCHD1 mutation, if known: _____
No or unknown _____