DLS RESEARCH & VENTURES
UNRAVELING THE OBVIOUS

Phone: 770-648-8951 | www.dlsrav.com

ACCESSION ID

DNexusA™

NEUROLOGICAL (NEURO) GENETIC TESTING REQUISITION FORM

Jennifer Knaack, Director
CLIA ID: 11D2114053
1700 Honey Creek Commons, Suite A,
Conyers GA 30013

PATIENT INFORMATION

Last Name | First Name | Middle Initial | D.O.B. | Biological Sex **Female** **Male**

Phone | Address, City, State, Zip

Ethnicity **African American** **Asian** **Native American** **Hispanic** **Ashkenazi Jew** **White** **Other** __

BILLING INFORMATION

Bill To **Client** **Patient** **Insurance (** **Attach patient demographics with a front and back of the insurance card)**

Insurance Company | Name of Insured

Subscriber ID | Group ID | Policy No.

ORDERING PROVIDER INFORMATION

Ordering Provider | NPI

Address

Provider Phone | Fax | Email

Requesting Physician/Provider (Signature Required)
I am legally authorized to order laboratory tests or I am an authorized representative of a health care professional legally authorized to order laboratory test(s). I hereby order the test requested on the entirety of this document, which includes any collection device(s) necessary to obtain the samples for testing. I hereby confirm that the test(s) are medically necessary for the treatment and/or plan of care for the patient, and that the information supplied on this form is accurate and true to the best of my knowledge.

Physican Signature | Date _____

SPECIMEN INFORMATION

Sample Type **Buccal Swab (Cheek Swab)** **Other** __ | Collection Date | Collection Time **AM** **PM** | Collector's Initials

TEST REQUESTED

Comprehensive Neurological Panel

ACADM, ADNP, AFF2, ALDH7A1, ANG, APOE, APP, APTX, ARSA, ARX, ASPA, ASXL1, ATM, ATN1, ATP3A2, ATP1A2, ATP1A3, ATP7B, ATXN1, ATXN10, ATXN2, ATXN3, ATXN7, ATXN8OS, BCKDHA, BCKHB, BCL11A, BCS1L, BLM, BSCL2, C10orf2 (TWNK), C12orf4, C9orf72, CACNA1A, CACNA1C, CC2D1A, CDKL5, CHD2, CNOT3, CNTN6, COL4A1, COL4A3BP, COQ2, COX10, CSF1R, CSNK2A1, CSTB, CTNND2, DCTN1, DGUOK, DHCR7, DNMT1, DPYD, EGR2, EHMT1, EIF4G1, EN2, ERBB4, EZH2, FANCC, FBXO11, FBX07, FMR1, FOXG1, FOXP1, FTSJ1, FUS, FXN, G6PC, GAA, GABRG 2, GALT, GAMT, GARS, GATM, GBA, GBE1, GCH1, GJB1, GRINTA, GRN, HBB, HEXA, HFE, HSPB1, HTRA2, HTT, IK BKAP, KCNQ2, KDM SC, L1AM, LRR K2, MAPT, MBO AT7, MCOLN1, MECP2, MED 12, MFN2, MPV17, MPZ, MTHFR, MTM1, NDP, NDUFA1, NLGN3, NLGN4X, NOTCH3, NPC1, NSD1, NTRK1, NTRK2, OPA1, OPTN, PABPN1, PAH, PARK 7, PCDH19, PDG FB, PDHA1, PDSS2, PIK3CA, PIN K1, PLA2G6, PLCG2, PMP 22, PN KD, POLG, POLG2, PPP2R2B, PRKN, PRKRA, PRNP, PRRT2, PSEN1, PSEN2, PTEN, REEP1, RRM2B, SCN1A, SCN 1B, SCN2A, SCN8A, SCO1, SCO2, SETX, SGCE, SLC16A2, SLC25A4, SLC2A1, SLC6A3, SLC6A8, SLC9A6, smn 1, SMN2 SNCA, SNCB, SOD1, SPAST, SPG11, SPTL C1, STXBP1, SUCL A2, SUCLG 1, SYNGAP1, TAF1, TARDBP, TAZ, TBP, TCF4, TH, THAP1, TK2, TPP1, TREM2, TSC1, TSC2, TTR, TYMP, TYROBP, UBA1, UCHL1, VPS35, CEB2, ZNF41

DIAGNOSIS

ICD 10 CODES

G98.8 Other disorders of nervous system
G43.019 Migraine without aura, intractable, without status migrainosus
G04.02 Postimmunization acute disseminated encephalitis, myelitis and encephalomyelitis
G24.09 Other drug induced dystonia
G00.9 Bacterial meningitis, unspecified
G47.00 Insomnia, unspecified
G21.11 Neuroleptic induced parkinsonism
G21.19 Other drug induced secondary parkinsonism
G21.2 Secondary parkinsonism due to other external agents
G21.3 Postencephalitic parkinsonism
G21.4 Vascular parkinsonism
G21.8 Other secondary parkinsonism
G21.9 Secondary parkinsonism, unspecified
G30.0 Alzheimer's disease with early onset
G30.1 Alzheimer's disease with late onset
G30.8 Other Alzheimer's disease
G30.9 Alzheimer's disease, unspecified
G40.1 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures
G40.2 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures
G40.3 Generalized idiopathic epilepsy and epileptic syndromes
G40.4 Other generalized epilepsy and epileptic syndromes
G40.5 Epileptic seizures related to external causes
G40.8 Other epilepsy and recurrent seizures
G40.9 Epilepsy, unspecified

PATIENT SIGNATURE (REQUIRED)

By signing below, I acknowledge that the genetic test is not for diagnosing present or future diseases but aims to reveal my genetic disposition concerning health, as discussed with my healthcare provider. I have had the chance to discuss the benefits and limitations of the test with my provider, including the reliability of results. I agree not to make medical decisions based on results without consulting my healthcare provider first. I confirm that I haven't received any inducements for providing my genetic sample. I retain ownership of my medical history, and my provider cannot disclose my results without my written authorization, except for treatment or payment purposes. I understand the voluntary nature of genetic testing and have read and comprehend the document, consenting to the test and agreeing to discuss results and medical management with my healthcare provider.

Patient Signature _____ Date _____

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PATIENT INFORMED CONSENT, AUTHORIZATION, AND ASSIGNMENT

I consent to have my testing performed by DLS RESEARCH & VENTURES I supplied accurate and true information with this form. If I supplied insurance information, I authorize payment of my insurance benefits directly to DLS RESEARCH & VENTURES. I authorize DLS RESEARCH & VENTURES to be my Designated Representative and to appeal any denial of health benefits. I understand DLS RESEARCH & VENTURES may be out of network with my plan, and I accept responsibility for paying to DLS RESEARCH & VENTURES any amounts my insurer determines are my responsibility after calculating deductibles, co-payments, and co-insurance due under my policy. I understand I am legally responsible for sending DLS RESEARCH & VENTURES any money received from my health insurance company for performance of this laboratory test. I understand that consent is not a condition of purchasing any goods or services. I allow the release of medical information necessary to process this claim. I also acknowledge that I have received or been offered the Notice of Privacy Practices (NOPP) by my healthcare provider(s). Additional copies of our NOPP can be obtained on DLS RESEARCH & VENTURES website at www.dlsrav.com.

I further assign and transfer to DLS RESEARCH & VENTURES all rights, claims and causes of action against any person or entity who may be financially responsible for payment of my charges, and I consent to DLS RESEARCH & VENTURES independently or jointly with me or others, pursuing recovery against such persons or entities on its own behalf or in my place for the charges incurred in my care. The claims and causes of action that I assign include, but are not limited to, claims, or causes of action that I may have relating to any Health Plan, insurance policy or health benefits plan or any other party under ERISA, under state insurance law and under state common law. I further assign all rights, claims or causes of action I may have to request and obtain documents from any Health Plan/and its affiliated insurers, employers and third party administrators that relate to coverage or non-coverage of benefits or payment of charges for medical care rendered, including, without limitation, my certificate of coverage, policy and/or summary plan description; any master policy or governing plan document that differs from the certificate of coverage, policy and/or summary plan description; copies of any policies or procedures used to decide my claim; and a complete copy of any other claims adjudication information so that DLS RESEARCH & VENTURES can determine if a full and fair review of my claim took place.

TESTING CONSENT

I consent to having analysis performed and the results of the analysis made available to my physician (where requested). This signed test requisition form authorizes DLS RESEARCH & VENTURES to perform the test and disclose the results to my medical practitioner (where requested). No tests other than those requested above will be performed. I authorize DLS RESEARCH & VENTURES to retain this specimen for future testing as requested as long as any necessary physician orders for such testing are obtained and/or provided.

HEALTH CARE PRACTITIONER CONSENT

I have provided the patient with information about the genetic test being ordered and have obtained written, informed consent from the patient, or their legal representative, as required by applicable state law. If this order is for a minor, by submitting this order I attest that I have obtained the appropriate prior written consent from the parent or person authorized to consent for the minor.
I attest that the test is to assist in managing the treatment for a current condition, disease, illness, impairment, symptom, or disorder. I also affirm that this test is reasonable and medically necessary for this patient.

FOOTNOTES

(1) If the patient is under the age of 18, the health care provider's signature is required. If the patient is 18 or older, either the health care provider's or the patient's signature is required.

TEST REPORT

Reported disease-causing variants are described as pathogenic variant(s), likely pathogenic variants(s), or variant(s) of uncertain significance in genes interpreted to be responsible for, or potentially contributing to, a disease or condition. In addition, variants in genes not known to be associated with disease but for which there is evidence to suggest an association with disease may also be reported. When Whole Exome Sequencing (WES) or Whole Genome Sequencing (WGS) tests are ordered by your HCP, you have the option to receive some findings not directly related to the reason for ordering the Test.

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I further assign and transfer to DLS RESEARCH & VENTURES all rights, claims and causes of action against any person or entity who may be financially responsible for payment of my charges, and I consent to DLS RESEARCH & VENTURES independently or jointly with me or others, pursuing recovery against such persons or entities on its own behalf or in my place for the charges incurred in my care. The claims and causes of action that I assign include, but are not limited to, claims, or causes of action that I may have relating to any Health Plan, insurance policy or health benefits plan or any other party under ERISA, under state insurance law and under state common law. I further assign all rights, claims or causes of action I may have to request and obtain documents from any Health Plan/and its affiliated insurers, employers and third party administrators that relate to coverage or non-coverage of benefits or payment of charges for medical care rendered, including, without limitation, my certificate of coverage, policy and/or summary plan description; any master policy or governing plan document that differs from the certificate of coverage, policy and/or summary plan description; copies of any policies or procedures used to decide my claim; and a complete copy of any other claims adjudication information so that DLS RESEARCH & VENTURES can determine if a full and fair review of my claim took place.

TESTING CONSENT

I consent to having analysis performed and the results of the analysis made available to my physician (where requested). This signed test requisition form authorizes DLS RESEARCH & VENTURES to perform the test and disclose the results to my medical practitioner (where requested). No tests other than those requested above will be performed. I authorize DLS RESEARCH & VENTURES to retain this specimen for future testing as requested as long as any necessary physician orders for such testing are obtained and/or provided.

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INFORMATION ABOUT PARENTAL AND FAMILIAL SAMPLES

In some circumstances, it may be helpful for additional family members to undergo testing in order to provide information that can aid in the interpretation of the WES/WGS test results. These Tests could be part of a TRIO Test or as stand-alone targeted testing. DLS RESEARCH & VENTURES, in consultation with the HCP, will decide if other family members need to be tested. If the HCP recommends testing for additional family members, only the Test performed will be reported. If undergoing a TRIO test (WES or WGS), parents will have the option of receiving a full parental report for an additional charge. If selected, the respective parental consent section must be completed below.

TEST LIMITATIONS

Due to current limitations in technology and incomplete knowledge of diseases and genes, some variants may not be detected by the Test ordered. There is a possibility that the Test result that is uninterpretable or of unknown significance may require further testing when more information is gained. In rare circumstances, Test results may be suggestive of a condition different from that which was originally considered for the purpose of consenting to this Test. The Test may also find variants or genes that lead to conditions for which you currently do not have symptoms or may not be related to your current condition.

Furthermore, all sequencing technologies have limitations. This analysis is performed by Next Generation Sequencing (NGS) and is designed to examine coding regions and splicing junctions. Although next generation sequencing technologies and our bioinformatics analysis significantly reduce the contribution of pseudogene sequences or other highly-homologous sequences, these may still occasionally interfere with the technical ability of the assay to identify pathogenic variant alleles in both sequencing and deletion/duplication analyses. Sanger sequencing is used to confirm variants with low quality scores and to meet coverage standards. If ordered, deletion/duplication analysis can identify alterations of genomic regions which include one whole gene (buccal swab specimens and whole blood specimens) and are two or more contiguous exons in size (whole blood specimens only); single exon deletions or duplications may occasionally be identified but are not routinely detected by this test. Identified putative deletions or duplications are confirmed by an orthogonal method (qPCR or MLPA). This assay will not detect certain types of genomic alterations which may cause disease such as, but not limited to, translocations or inversions, repeat expansions (e.g., trinucleotides or hexanucleotides), alterations in most regulatory regions (promoter regions) or deep intronic regions (greater than 20bp from an exon). This assay is not designed or validated for the detection of somatic mosaicism or somatic mutations.

TEST RISKS

Patients and family members may experience anxiety before, during, and/or after testing. Testing multiple family members may reveal that familial relationships are not biologically what they were assumed to be. For example, the Test may indicate nonpaternity (the stated father of an individual is not the biological father) or consanguinity (the parents of an individual are closely related by blood). These biological relationships may need to be reported to the HCP who ordered the test.

Under some circumstances an additional sample may be required for Tests to be performed. A positive test result may limit your access to health insurance or life assurance coverage; for example, a life insurance company might ask you to provide genetic information indicating a disorder if this information is available to you. Please refer to information on the Genetic Information Nondiscrimination Act (GINA) and applicable local laws for more information.

Patient Signature _____ Date _____