Medical Director: Hussam Al-Kateb, MSc, PhD, FACMGG
CLIA #: 03D2055105

Mail Specimens to:
University of Arizona Genetics Core Division of Clinical Services
Keating Bioresearch Building
1657 E. Helen Street Room 111H
Tucson, AZ 85721
Phone: (520)626-5002 Fax: (520)626-7701
http://uagcclinical.arizona.edu/

Clinical Exome Sequencing

ORDERING PHYSICIAN INFORMATION

Ordering Physician First Name:	Last Name:	Middle Initial:	Title/Specialty:

Clinic/Institution:	NPI:	State License #:	Medicare/Medicaid PTAN:	Federal Tax ID:

Address Line One:	Address Line Two:

City:	State:	Zip:	Phone:	Fax:

E-mail Address:	Requisitioner (if different):	Requisitioner Phone:

PROBAND INFORMATION

Patient's First Name:	Last Name:	Middle Initial:	MRN or Other ID (non-SSN):

DOB (mm/dd/yyyy):	Age:	Gender: ☐ Male ☐ Female ☐ Other	Ethnic Background:	Parent/Guardian Full Name (if patient is under 18 years of age):

Address Line One:	Address Line Two:

City:	State:	Zip:	Home Phone:	Work Phone:	Cell Phone:

Email:	Notes:

Receipt of Incidental findings, Research & Re-contact Consent: UAGC-CS is committed to improving genetic testing for all patients and contributing to scientific research.
NOTE: If left blank, consent is interpreted as "NO".

☐ Yes, I would like to receive information about secondary findings identified in the updated list of medically actionable genes (total 59 genes) associated with various inherited disorders as recommended by the ACMG (Kalia et al, Genetics in Medicine (2017) 19, 249–255).
☐ I agree to share my de-identified health and genomic information.
☐ I agree to use of my de-identified bio-specimen for research.
☐ I agree to be contacted in the future regarding the use of my identifiable bio-specimen or data for scientific research.

SPECIMEN AND PROBAND'S CLINICAL INFORMATION

Patient Medical Background

	Description		Description
Perinatal History:		**Dysmorphology:**	
Developmental Delay:		Facial	
Physical		Hair	
Cognitive		Eye-brows	
Intellectual Disability, IQ:		Eyes	
Mild		Ears	
Moderate		Nose	
Severe		Lips	
Profound		Teeth	
Developmental Regression:		Chin	
Growth:		**Organ Systems:**	
Overgrowth		Cardiovascular	
Growth Retardation		Neurologic	
Behavioral:		Genitourinary	
Autism/Autistic Spectrum		Liver	
Movement:		Skin	
Joints:		Muscular	
Other (please describe):		Gastrointestinal	
		Endocrine	
		Metabolic	
		Hematologic	

ICD-10 Diagnosis Code:	Indication:

Additional Clinical Features (attach extra documentation as necessary):

Family History (please attach pedigree):

Differential or Suspected Diagnosis:

Candidate Genes:

Specimen ID:	Sample Type:	Collected By:	Date of Collection (mm/dd/yyyy):

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FAMILY MEMBERS TO BE TESTED IN ADDITION TO PATIENT

First Name:	Last Name:	Middle Initial:	DOB (mm/dd/yyyy):
Address Line One:	Ethnic Background:	Relationship To Patient:	Gender: ☐ Male ☐ Female ☐ Other
Address Line Two:	City:	State:	Zip:
Specimen ID:	Sample Type:	Collected By:	Date of Collection (mm/dd/yyyy):

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NOTE: If left blank, consent is interpreted as "NO".

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- ☐ I agree to use of my de-identified bio-specimen for research.
- ☐ I agree to be contacted in the future regarding the use of my identifiable bio-specimen or data for scientific research.

First Name:	Last Name:	Middle Initial:	DOB (mm/dd/yyyy):
Address Line One:	Ethnic Background:	Relationship To Patient:	Gender: ☐ Male ☐ Female ☐ Other
Address Line Two:	City:	State:	Zip:
Specimen ID:	Sample Type:	Collected By:	Date of Collection (mm/dd/yyyy):

Receipt of Incidental findings, Research & Re-contact Consent: UAGC-CS is committed to improving genetic testing for all patients and contributing to scientific research.
NOTE: If left blank, consent is interpreted as "NO".

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- ☐ I agree to use of my de-identified bio-specimen for research.
- ☐ I agree to be contacted in the future regarding the use of my identifiable bio-specimen or data for scientific research.

First Name:	Last Name:	Middle Initial:	DOB (mm/dd/yyyy):
Address Line One:	Ethnic Background:	Relationship To Patient:	Gender: ☐ Male ☐ Female ☐ Other
Address Line Two:	City:	State:	Zip:
Specimen ID:	Sample Type:	Collected By:	Date of Collection (mm/dd/yyyy):

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- ☐ I agree to be contacted in the future regarding the use of my identifiable bio-specimen or data for scientific research.

PAYMENT INFORMATION

Please include a clear copy of the front and back of all Insurance Cards

Primary Insurance Provider:	Policy Holder's Name (if different):	DOB (mm/dd/yyyy):	Relationship to Patient:
Policy/Group#:	Payer/Provider ID:	Company Phone:	Company Fax:
Secondary Insurance Provider:	Policy Holder's Name (if different):	DOB (mm/dd/yyyy):	Relationship to Patient:
Policy/Group#:	Payer/Provider ID:	Company Phone:	Company Fax:

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Clinical Exome Sequencing

HEALTHCARE PROVIDER SIGNATURE TO AUTHORIZE TESTING, STATEMENT OF MEDICAL NECESSITY, AND AUTHORIZATION FROM PATIENT TO RELEASE PHI TO UAGC CLINICAL SERVICES (TO BE COMPLETED BY PROVIDER)

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

I authorize the University of Arizona Genetic Core (UAGC) Division of Clinical Services Laboratory to receive Protected Health Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) at the facsimile phone number above. I acknowledge that I am responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.

- To comply with HIPAA regulations, any transmission of PHI (e.g. clinical report) must be sent securely.
- The undersigned Provider authorizes the University of Arizona Genetic Core (UAGC) Division of Clinical Services to send and receive Protected Health Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number listed on the requisition.
- Provider acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.
- In the event of an erroneous transmission, Provider must immediately notify the sender and to destroy the results.
- Provider may revoke this authorization or change the facsimile number by giving the UAGC at least 24 hours' prior notice either verbally or in writing.

Signature of Provider (REQUIRED):	**Printed Name:**	**Date:**

CERTIFICATION OF INFORMATION AND APPROVAL TO RETRIEVE BENEFITS INFORMATION (TO BE COMPLETED BY PATIENT)

I authorize the disclosure of insurance benefit coverage and payment information to The University of Arizona Genetics Core (UAGC) Division of Clinical Services. I authorize UAGC to furnish any medical information requested on myself, or my covered dependents. I assign and authorize insurance payments to UAGC. I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if UAGC is not a participant with my health plan, and/or my health plan does not fully reimburse medical services due to lack of authorization or medical necessity.

By signing below, I certify that the information about me provided in this form is true and correct to the best of my knowledge.

Signature of Patient or Guardian (REQUIRED):	**Printed Name:**	**Date:**

PROVIDER'S INSTRUCTIONS FOR COMPLETING FILLABLE PDF AND SENDING COMPLETED REQUISITION

Complete the requisition and **mail** with the specimen to the address at the top of this form or **fax** to (520)626-7701

- If the requisition is to be emailed to **<email TBD>**, it must be saved as a JPEG (or other non-editable file format), or as a PDF encrypted with a password.
  - **To save form as a JPEG on a PC:** Complete the form in Adobe Reader, then choose "File" > "Save As > "Save As Type" > JPEG.
  - **To save form as a JPEG on a Mac:** Complete the form in Preview, then choose "File" > "Export"> "JPEG" > "Save".
  - **To encrypt a PDF form on a PC:** Complete the form in Adobe Reader (v7.0 or later), then choose "Secure" > "Encrypt with Password". Select "Require a Password to Open the Document", enter and confirm a password, save and close. Send password and requisition in separate emails.
  - **To encrypt a PDF form on a Mac:** Complete the form in Preview, then choose "File" > "Export". Check "Encrypt", enter and verify a password, save and close. Send password and requisition in separate emails.

UAGC USE ONLY

UAGC Accession Number:	**Date Received (mm/dd/yyyy):**	**Receiving Personnel:**