GENERAL TEST REQUISITION FORM

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

PRIMARY PATIENT

LAST NAME	FIRST NAME		
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ◯ Male ◯ Female ◯ Unknown		
MED REC#/PATIENT IDENTIFIER	ETHNICITY		
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE	EMAIL		
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE ◯ Blood ◯ Buccal ◯ Other: ◯ Extracted DNA & DNA Source: (Blood, Buccal, Tissue, Fibroblast)		

I have read the Informed Consent document and I give permission to Tesis Labs to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Tesis Labs and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available

☐ Opt out of research

☐ **Check this box if you are a New York state resident and give permission for Tesis Labs to retain any remaining sample longer than 60 days after the completion of testing.**

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES)	DATE (MM/DD/YYYY)
X	

ORDER PROVIDER

INSTITUTION/PRACTICE NAME		INSTITUTION PHONE/FAX/EMAIL	
PROVIDER LAST NAME		PROVIDER FIRST NAME	
NPI (USA)	MINC (CANADA)	PROVIDER TITLE (MD, DO, GC)	
PROVIDER ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PROVIDER PHONE		FAX REPORT TO	
GC/PRIMARY CONTACT		GC/PRIMARY CONTACT PHONE/EMAIL/FAX	

I attest that the patient has received and read the Tesis Labs Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Tesis Labs Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

ORDERING PROVIDER SIGNATURE (REQUIRED)	DATE (MM/DD/YYYY)
X	

TEST REQUESTED

TEST NAME

Connective Tissue NGS Panel

+ADD/-MINUS GENES

TEST SPECIFICS

Ex: DUO/TRIO (requires additional info/consent for testing, see Page 2), Repeat expansion, Known mutation(s), Hold samples, Additional report delivery, etc...

☐ For Clinical or Whole Exome: Check this box if you wish to receive ACMG secondary findings. If checked, a signed Informed Consent Form is required to be submitted.

TEST OPTIONS

Omitted test options will default to Seq & Del/Dup. Additional charges may apply.

◯ Seq & Del/Dup
◯ Sequencing Only
◯ Del/Dup Only

REFLEX OPTIONS

Reflex options may not be available for all tests. Additional charges will apply.

◯ All-in-One (Extended)
◯ Whole-in-One

ORDER OPTIONS

Additional charges may apply.

☐ Prenatal ☐ Exclude VUS
☐ MCC ☐ Rush/STAT

INDICATIONS FOR TESTING

Check all that apply.

☐ Diagnostic
☐ Presymptomatic
☐ Family History
☐ Family Variant
☐ Other:

CLINICAL/SUSPECTED DIAGNOSIS: Please attach medical records or complete Page 2.

The lab may perform confirmation of parental relationships for quality control or other purposes. See the attached informed consent for more details. ☐ Check here to opt-out.

INSURANCE BILLING

Attach front and back of all insurance cards, ABN, medical criteria form

PLEASE ATTACH INSURANCE CARDS FOR BILLING	ICD-10 VALID CODE	REFERRAL/PRIOR AUTH	Tesis Labs Benefit ID #	By signing above, the patient or insured authorizes Tesis labs to release medical information concerning the test to the assigned insurance company.

PRIMARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)

INSTITUTIONAL BILLING

INSTITUTION/PRACTICE NAME			
ATTENTION TO			
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE	FAX/EMAIL		

SELF PAY

◯ Use patient information above for billing
◯ Use information below for billing

By signing above, the patient or payor authorizes Tesis Labs to contact them directly, and use the provided billing instructions to bill the indicated method.

PAYOR LAST NAME	PAYOR FIRST NAME		
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE	FAX/EMAIL		

GENERAL TEST REQUISITION FORM

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CLINICAL HISTORY

Attach any available detailed medical records and clinical notes

Clinical Details

Check all that apply:

- ☐ Mosaicism
- ☐ Bone Marrow Transplant
- ☐ Known Chromosomal Gain/Loss
- ☐ Consanguinity
- ☐ Organ Transplant
- ☐ Known Gene Gain/Loss

Please specify any that are checked above:

There are many factors which may affect genetic diagnostic testing: such as gene-gene interactions, high-risk ethnicity groups, and transplants. Please list any that may apply.

Clinical Presentation

Please indicate any clinical presentations and/or findings that may be relevant to genetic testing:

- Behavior
- Conditions
- Pedigree/Family History
- Phenotypes
- Physical
- Symptoms

There are many presentations which may not seem like a direct association for disease. Please list the most suspected presentations and attach detailed medical records and/or pedigree.

Clinical Testing

Please indicate any clinical testing results and/or findings that may be relevant to genetic testing:

- Karyotype
- Previous Genetic Testing
- Vision
- Hearing
- Growth Measurements
- Biochemical Testing
- Imaging
- Pathology Reports

Please also include tests that had a negative result. These tests help our clinical staff process the results of your testing.

FAMILY HISTORY

Attach pedigree and additional pages as needed

FAMILY MEMBER 1 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown
DIAGNOSIS AND/OR SYMPTOMS	AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 2 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown
DIAGNOSIS AND/OR SYMPTOMS	AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 3 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown
DIAGNOSIS AND/OR SYMPTOMS	AGE OF ONSET	DOB (MM/DD/YYYY)

FAMILY SAMPLES FOR DUO/TRIO TESTING

Complete this section if family samples have been submitted for testing

LAST NAME	FIRST NAME
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ◯ Male ◯ Female ◯ Unknown
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE ◯ Blood ◯ Buccal ◯ Other: ◯ Extracted DNA & DNA Source: (Blood, Buccal, Tissue, Fibroblast)
RELATION TO PRIMARY PATIENT	AFFECTED/UNAFFECTED STATUS

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- ☐ Opt out of research
- ☐ Check this box if you are a New York state resident and give permission for Tesis Labs to retain any remaining sample longer than 60 days after the completion of testing.

FAMILY MEMBER SIGNATURE X	DATE (MM/DD/YYYY)

LAST NAME	FIRST NAME
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ◯ Male ◯ Female ◯ Unknown
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE ◯ Blood ◯ Buccal ◯ Other: ◯ Extracted DNA & DNA Source: (Blood, Buccal, Tissue, Fibroblast)
RELATION TO PRIMARY PATIENT	AFFECTED/UNAFFECTED STATUS

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- ☐ Check this box if you are a New York state resident and give permission for Tesis Labs to retain any remaining sample longer than 60 days after the completion of testing.

FAMILY MEMBER SIGNATURE X	DATE (MM/DD/YYYY)

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Genes:

ABCC6, ACTA2, ADAMTS2, AEBP1, ALDH18A1, ATP6V0A2, ATP6V1E1, B3GALT6, B3GAT3, B4GALT7, BGN, C1R, C1S, CBS, CHST14, COL11A1, COL11A2, COL12A1, COL1A1, COL1A2, COL2A1, COL3A1, COL4A1, COL5A1, COL5A2, COL9A1, COL9A2, CRTAP, DSE, EFEMP2, ELN, FBLN5, FBN1, FBN2, FKBP14, FLNA, LOX, LTBP4, MAT2A, MED12, MFAP5, MYH11, MYLK, NOTCH1, P3H1, PLOD1, PRDM5, PRKG1, PYCR1, RIN2, SGMS2, SKI, SLC2A10, SLC39A13, SMAD3, SMAD4, TGFB2, TGFB3, TGFBR1, TGFBR2, TNXB, ZNF469

(62 genes)

INSTRUCTIONS

1. Complete the patient and provider information section.
2. Read and sign the informed consent policy statement. The complete patient informed consent form for genetic testing can be found on Tesis Labs Signature from the provider on Page 1 of the TRF is required for all testing. Signature from the patient is only required for billing purposes.
3. Write in the test name and indicate any relevant test options. Please call us if you have any questions.
4. Add-on any additional genes. Visit our website for our most updated list of 18,000+ available genes.
5. For Duo/Trio testing, please complete the Family Samples section or submit a separate TRF for each sample.
6. Please visit Tesis Labs for specimen requirements.
   Extracted DNA must extracted from a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by CAP and/or CMS.

REQUIRED FOR INSURANCE CHECKLIST

- ☐ Detailed medical record (pedigree if available)
- ☐ ICD-10 codes(s)
- ☐ Physician, patient, and insured signatures
- ☐ Copy of insurance card(s) - front/back
- ☐ Insurer specific forms (i.e. ABN)
- ☐ Insurance authorization, if available
- ☐ For medicare, medicare criteria form is required

For the most updated information and limitations on our products and services, please visit Tesis Labs