Laboratory of Personalized Genomic Medicine
Department of Pathology and Cell Biology

COLUMBIA UNIVERSITY MEDICAL CENTER

630 West 168th Street
P&S 17th Floor, Room 401
New York, NY 10032
Tel: 212-305-9706
Fax: 212-342-0420

Genetic Carrier Screening Requisition

Must be filled out completely. Informed Consent MUST be signed by Patient, Parent/Legal Guardian or Legal Next of Kin.

Internal Use Only Accession #:_____

SAMPLE INFO

DATE COLLECTED (MM/DD/YY) | TIME COLLECTED AM PM

DATE SENT | FROZEN ☐ YES ☐ NO

COLLECTED BY

PATIENT INFORMATION

LAST NAME | FIRST NAME | M.I.

DATE OF BIRTH (MM/DD/YY) | MRN | SEX ☐ MALE ☐ FEMALE

ADDRESS

CITY/STATE/ZIP

HOME PHONE | WORK PHONE

ORDERING PHYSICIAN INFORMATION

CLINICIAN NAME | EMAIL

INSTITUTION | TELEPHONE NUMBER

ADDRESS | CITY/STATE/ ZIP

SIGNATURE | DATE

NOTE TO HEALTH CARE PRACTITIONER: It is New York State Law and Columbia University Policy that an informed consent is obtained prior to performing genetic predisposition testing and maintained in the patient's medical record. Please use the appropriate disease/gene information/informed consent sheet, ensure that the patient/legal guardian understands its contents, and obtain the person's signature. If the patient consents to having the sample retained in the lab for greater than 60 days, please include a copy of the consent form with this requisition. **I have obtained a signed informed consent to perform genetic testing in accordance with New York State Civil Rights Law, 79-L, and the informed consent is retained in the patient's medical record.:** ☐

CLINICAL INFORMATION

ETHNICITY ☐ ASIAN ☐ BLACK / AFRICAN - AMERICAN ☐ CAUCASIAN ☐ HISPANIC ☐ JEWISH, ASHKENAZI ☐ JEWISH, NON - ASHKENAZI ☐ OTHER

Family History of Genetic Condition? (1st, 2nd, or 3rd degree relative) ☐ YES ☐ NO SPECIFY CONDITION _____

Is patient pregnant? ☐ YES ☐ NO | Is patient on oral contraception? ☐ YES ☐ NO

MATERNAL WEIGHT LBS | DUE DATE (MM/DD/YY) | Is patient insulin-dependent diabetic? ☐ YES ☐ NO

GESTATIONAL AGE WEEKS DAYS | CALCULATED ON DATE (MM/DD/YY) | DATING METHOD ☐ LMP ☐ U/S

Multiple gestation pregnancy? ☐ YES ☐ NO ☐ UNKNOWN

Did patient use an egg donor? ☐ YES ☐ NO AGE OF DONOR _____

Did patient use a surrogate? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED | DATE OF BIRTH

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME OF INSURANCE COMPANY:

ADDRESS

POLICY #: | GROUP #:

PREAUTHORIZATION: If health insurance preauthorization is required, check here if preauthorization is pending: ☐

INSTITUTIONAL BILLING (CLINICIAN): Do you have a PGM Billing Account?
☐ Yes P.O. #_____
☐ No (Email PGMinquiry@cumc.columbia.edu to establish an account)

CREDIT CARD (PATIENT): I have provided my credit card information to the Pathology Billing Office (call 212-305-7399 to provide card information). ☐

MEDICARE PATIENTS ONLY: Check here to confirm that an Advance Beneficiary Notice (**ABN**) was signed by the Patient: ☐

GENETIC CARRIER SCREENING

- ☐ **Cystic Fibrosis ONLY**
- ☐ **Spinal Muscular Atrophy (SMA) ONLY**
- ☐ **FMR1 - Fragile X ONLY**
- ☐ **EXPANDED SCREENING: Cystic Fibrosis + SMA + Fragile X**
- ☐ **Thrombophilia Risk Panel 1**
  Factor V Leiden
  Prothrombin 20210G>A
- ☐ **Thrombophilia Risk Panel 2**
  Factor V Leiden
  MTHFR Mutations
  Prothrombin 20210G>A
- ☐ **Ashkenazi Jewish Carrier Screening Panel**

Bloom Syndrome	Fanconi Anemia Type C	Nemaline Myopathy
Canavan Disease	Gaucher Disease	Niemann-Pick Disease Types A & B
Cystic Fibrosis	Glycogen Storage Disease A & B	Spinal Muscular Atrophy
Dihydrolipoamide Dehydrogenase Deficiency	Joubert Syndrome	Tay-Sachs disease (DNA)
Familial Dysautonomia	Maple Syrup Urine Disease Types Ia & Ib	Usher Syndrome Type IF & Type III
Familial Hyperinsulinism	Mucolipidosis Type IV	Walker- Warburg Syndrome

- ☐ **Pan Ethnic Carrier Screening** (Refer to the disorder categories listed on the right)
- ☐ **Familial Confirmation Testing / Sanger Sequencing of Targeted Gene**

GENE: _____ VARIANT OF INTEREST: _____

To order individual test components not listed above, please contact the Columbia University Laboratory for Personalized Genomic Medicine at PGMinquiry@cumc.columbia.edu.

CLINICAL INDICATIONS

Ordering Clinician should report the diagnosis that best describes the reason for performing the test. Mark all that are appropriate.

- ☐ Screening for genetic disease carrier status
- ☐ Testing of female for genetic carrier status
- ☐ Testing of male for genetic carrier status
- ☐ Screening for Cystic Fibrosis
- ☐ Other genetic screening
- ☐ Family history of genetic disease carrier
- ☐ Family history of other musculoskeletal disease
- ☐ Supervision of normal first pregnancy
- ☐ Supervision of other normal pregnancy
- ☐ Pregnant state, incidental
- ☐ **ICD-10 Code(s)**

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PAN-ETHNIC CARRIER SCREENING DISORDERS

Alpha-1 Antitrypsin Deficiency
Alpha-Mannosidosis
Argininosuccinate Lyase Deficiency
Ataxia with Vitamin E Deficiency
Ataxia- Telangiectasia
Autoimmune Polyendocrine Syndrome Type I
Autosomal Recessive Polycystic Kidney Disease
Beta-Ketothiolase Deficiency
Biotinidase Deficiency
Bloom Syndrome
Canavan Disease
Carnitine Palmitoyltransferase II Deficiency
Carnitine Palmitoyltransferase Ia Deficiency
Cartilage-hair Hypoplasia
Citrullinemia Type I
Congenital Disorder of Glycosylation Type Ia
Congenital Disorder of Glycosylation Type Ib
Connexin 26 Deafness
Connexin 30 Deafness
Cystic Fibrosis
Cystinosis
Dihydrolipoamide Dehydrogenase Deficiency
Early-onset Primary Dystonia
Fabry Disease
Factor XI Deficiency
Familial Dysautonomia
Familial Hyperinsulinism
Familial Mediterranean Fever
Fanconi Anemia Type C
Galactosemia
Gaucher Disease
Glucise-6-phosphate Dehydrogenase Deficiency
Glutaric Acidemia Type I
Glycogen Storage Disease Type Ia
Glycogen Storage Disease Types Ib, II, III, and V
Hemochromatosis Type I
Hereditary Fructose Intolerance
Herlitz Junctional Epidermolysis Bullosa, LAMB3 related
Herlitz-Junctional Epidermolysis Bullosa, LAMC2 related
Homocystinuria
Inclusion Body Myopathy Type II
Isovaleric Acidemia
Joubert Syndrome
Krabbe Disease
Long Chain 3-hydroxyacyl-CoIA Dehydrogenase Deficiency
Maple Syrup Urine Disease Type II
Maple Syrup Urine Disease Types Ia and Ib
Medium Chain acyl-CoA Dehydrogenase Deficiency
Metachromatic Leukodystrophy
Methylmalonic Aciduria, clbC Type
Methymalonic Aciduria, MMAA-, MMAB-, & MUT-related
Mucolipidosis Type II/IIIa
Mucolipidosis Type IV
Mucopolysaccharidosis Type I
Mucopolysaccharidosis Type II
Mucopolysaccharidosis Types IIIa and IIIb
Mucopolysaccharidosis Types IVa and IVb
Mucopolysaccharidosis Types VI and VII
Muscle-Eye-Brain Disease
Nemaline Myopathy
Niemann-Pick Disease Type C1
Niemann-Pick Disease Types A and B
Ornithine Transcarbamylase Deficiency
Pendred Syndrome
Phenylketonuria
Primary Carnitine Deficiency
Rhizomelic Chondrodysplasia Punctata
Sandhoff Disease
Short Chain acyl-CoA Dehydrogenase Deficiency
Sjogren-Larsson Syndrome
Smith-Lemli-Opitz Syndrome
Spinal Muscular Atrophy
Sulfate Transporter-Related Osteochondrodysplasias
Tay-Sachs Disease (DNA)
Tyrosinemia Type I
Usher Syndrome Types If and III
Very Long Chain acyl-CoA Dehydrogenase Deficiency
Walker-Warburg Syndrome
Wilson Disease
Zellweger Syndrome

COLLECTION REQUIREMENTS *(Samples not to exceed 3 tubes, regardless of testing)*

Cystic Fibrosis ..... (1) 4 mL Lavender-top EDTA Tube	**Thrombophilia Risk Panel** ..... (1) 4mL Lavender-top EDTA Tubes
Spinal Muscular Atrophy ..... (1) 4mL Lavender-top EDTA Tube	**Ashkenazi Jewish Carrier Screening Panel** ..... (1) 4mL Lavender-top EDTA Tubes
Fragile X ..... (1) 4mL Lavender-top EDTA Tube	**Pan Ethnic Carrier Screening** ..... (1) 4mL Lavender-top EDTA Tubes
Expanded Screening: CF, SMA, FX ....(2) 4mL Lavender-top EDTA Tubes	**Familial Confirmation Testing** ..... (1) 4mL Lavender-top EDTA Tubes