COLUMBIA UNIVERSITY
Vagelos College of Physicians and Surgeons

Laboratory of Personalized Genomic Medicine (PGM)
Department of Pathology & Cell Biology

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PGMINQUIRY@cumc.columbia.edu

Genetic Test Requisition Form

Internal Use Only - Accession #:_____

Informed consent MUST be signed by the Patient, Parent/Legal Guardian or Legal Next of Kin. Please contact PGMINQUIRY@cumc.columbia.edu for consent forms.

PATIENT INFORMATION:

LAST NAME: FIRST NAME: M.I.:

DATE OF BIRTH: MRN: GENDER: ☐ MALE ☐ FEMALE

ADDRESS:

CITY, STATE & ZIP:

HOME PHONE: WORK PHONE:

INSURANCE INFORMATION:

NAME OF POLICY HOLDER: DATE OF BIRTH:

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ SPOUSE ☐ CHILD ☐ OTHER (specify):

NAME & ADDRESS OF INSURANCE COMPANY:

POLICY NUMBER: GROUP NUMBER:

SECONDARY INSURANCE CARRIER: NAME OF POLICY HOLDER:

POLICY NUMBER: GROUP NUMBER:

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

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

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

ORDERING PHYSICIAN INFORMATION:

LAST NAME: FIRST NAME: M.I.:

INSTITUTION: NPI #:

ADDRESS:

CITY, STATE & ZIP:

TELEPHONE NUMBER: FAX NUMBER:

EMAIL ADDRESS:

SIGNATURE: DATE:

GENETIC COUNSELOR NAME: EMAIL ADDRESS:

INSTITUTIONAL BILLING: Do you have a PGM Billing Account?

☐ Yes P.O. #_____

☐ No (Email PGMINQUIRY@cumc.columbia.edu to establish an account)

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.:** ☐

SAMPLE INFORMATION:

☐ Amniotic Fluid ☐ Chorionic Villi ☐ Products of Conception ☐ Peripheral Blood ☐ Buccal Swab ☐ Muscle ☐ DNA (contact laboratory)
☐ Other (contact laboratory)

Collection Date: _____

ICD-10 CODES *List Below*

TEST ORDERED (FILL IN COMPLETELY):

MOLECULAR TESTING

☐ **Huntington Disease (HTT) – CAG Repeat Expansion**

☐ **C9orf72 GGGGCC Repeat Expansion**

☐ **Fragile X (FMR1) CGG Repeat Expansion**

☐ **Spinal Muscular Atrophy - SMN Copy Number**

☐ **Thrombophilia Risk Panel** ☐ **APOE Genotyping**

- Factor V Leiden
- Prothrombin 20210G>A Mutations

MITOCHONDRIAL DISEASES

☐ **mtDNA Whole Genome Sequencing**

☐ **Southern Blot for Mitochondrial DNA Rearrangements**

☐ **Mitochondrial DNA Depletion**

CHROMOSOMAL MICROARRAY

☐ **SNP Oligonucleotide Microarray Analysis (SOMA)**

Cytoscan HD* *Select Test Type*

☐ TARGETED ☐ WHOLE GENOME

Method subject to change at discretion of Pathologist

*Maternal cell contamination (MCC) studies will be performed on all fetal samples

Collection Requirements

General Information:

No special patient preparation is required. Specimens should be obtained and labeled as per standard hospital protocols including, but not limited to, labeling with two unique patient identifiers (i.e. Name and MRN or D.O.B.). Pathology specimens not from CUMC should have accompanying pathology reports to ensure identity.

Assay Specific Specimen Requirements:

Huntington, C9orf72, Fragile X, Spinal Muscular Atrophy, Thrombophilia, APOE: Peripheral blood: (1) 3-5 mL Lavender-top EDTA tube; room temperature or refrigerated, or buccal swab (APOE)

Mitochondrial Testing: Muscle tissue: flash frozen, 100-150 mg, approximately 0.1 cm in diameter and 0.5 cm in length, on Dry Ice OR Peripheral blood: (1) 3-5 mL Lavendar-top EDTA; room temperature or refrigerated

SOMA: Peripheral blood; (1) 3-5 mL Lavender-top EDTA tube; room temperature or refrigerated. For other prenatal specimen requirements, please contact the laboratory.

DNA: must be extracted in a CLIA-certified laboratory. Please contact the laboratory for assay-specific DNA requirements.