GENESYS Diagnostics INC.

Cardiology Next Generation Sequencing Requisition Form

*Information required for testing

Patient Information

LAST NAME* FIRST NAME* MI DOB* (MM/DD/YYYY) SEX

ADDRESS CITY STATE ZIPCODE PHONE NUMBER EMAIL ADDRESS

Billing Information (Please include a copy of insurance card(s) for billing purposes.)

*☐ CLIENT BILL ☐ INSURANCE ☐ SELF PAY ☐ MEDICARE/MEDICAID (☐ PRIMARY ☐ SECONDARY) RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

INSURANCE NAME MEMBER/POLICY ID GROUP #

POLICY HOLDER NAME POLICY HOLDER DOB (MM/DD/YYYY) TEST INDICATION/ICD-10 CODE(S)*

Account Information

FACILITY/PRACTICE NAME* PHONE NUMBER FAX NUMBER ORDERING PHYSICIAN NAME*

Specimen Information PREFERRED SPECIMEN IS BUCCAL SWAB

☐ BLOOD IN EDTA (5ml MIN) ☐ BUCCAL SWAB ☐ DNA (10 ug MIN) COLLECTION DATE:_____MM/DD/YYYY_____ COLLECTION TIME:_____00:00 AM/PM_____

Background Information (Please check all that apply)

RACE AND ETHNICITY: ☐ WHITE ☐ ASIAN ☐ HISPANIC ☐ AFRICAN AMERICAN ☐ ASHKENAZI JEWISH ☐ OTHER (PLEASE SPECIFY):_____

GENE PANEL NAME* (Must choose at least one)	GENES **
☐ CARDIOLOGY FULL PANEL (ALL 174 GENES LISTED BELOW)	☐ INDIVIDUAL GENE TESTING: INDICATE BY CIRCLING GENES BELOW OR LISTING_____
☐ AORTOPATHY COMPREHENSIVE PANEL (24 GENES)	ACTA2, ABCG5, ABCG8, APOC2, APOE, CBS, COL3A1, COL5A1, COL5A2, EFEMP2, FBN1, FBN2, HCN4, MYH11, MYLK, NOTCH1, SLC2A10, SMAD3, SMAD4, TBX20, TGFB2, TGFB3, TGFBR1, TGFBR2
☐ ARRHYTHMIA & CARDIOMYOPATHY COMPREHENSIVE PANEL (134 GENES)	ABCC9, ACTA1, ACTC1, ACTN2, AKAP9, ALMS1, ANK2, ANKRD1, BAG3, BRAF, CACNA1C, CACNA2D1, CACNB2, CALM1, CALR3, CASQ2, CAV3, CBL, CBS, COX15, CRYAB, CSRP3, CTF1, DES, DMD, DNAJC19, DOLK, DPP6, DSC2, DSG2, DSP, DTNA, EMD, EYA4, FHL1, FHL2, FKRP, FKTN, FXN, GAA, GATAD1, GJA5, GLA, GPD1L, HCN4, HFE, HRAS, HSPB8, ILK, JPH2, JUP, KCNA5, KCND3, KCNE1, KCNE2, KCNE3, KCNH2, KCNJ2, KCNJ5, KCNJ8, KCNQ1, KLF10, KRAS, LAMA2, LAMA4, LAMP2, LDB3, LMNA, LTBP2, MAP2K1, MAP2K2, MIB1, MURC, MYBPC3, MYH6, MYH7, MYL2, MYL3, MYLK2, MYO6, MYOZ2, MYPN, NEXN, NKX2-5, NPPA, NRAS, PDLIM3, PKP2, PLN, PRDM16, PRKAG2, PRKAR1A, PTPN11, RAF1, RANGRF, RBM20, RYR1, RYR2, SALL4, SCN1B, SCN2B, SCN3B, SCN4B, SCN5A, SCO2, SEPN1, SDHA, SGCB, SGCD, SGCG, SHOC2, SLC25A4, SNTA1, SOS1, TAZ, TBX3, TBX5, TBX20, TCAP, TGFB3, TMEM43, TMPO, TNNC1, TNNI3, TNNT2, TPM1, TRDN, TRIM63, TRPM4, TTN, TTR, TXNRD2, VCL, ZBTB17
☐ CONGENITAL HEART DISEASE PANEL (24 GENES)	ACTC1, ALMS1, BRAF, CBL, CRELD1, ELN, HRAS, JAG1, KRAS, MAPK2K1, MAPK2K2, MYH6, NKX2-5, NODAL, NOTCH1, NRAS, PTPN11, RAF1, SALL4, SCN5A, SHOC2, SOS1, TBX5, ZIC3
☐ FAMILIAL HYPERCHOLESTEROLEMIA (15 GENES)	APOA4, APOA5, APOB, CETP, CREB3L3, GCKR, GPIHBP1, HADHA, LDLR, LDLRAP1, LMF1, LPL, PCSK9, SREBF2, ZHX3

Patient Authorization and Consent

It has been explained to me and I understand that I am voluntarily providing a specimen for a genetic test. I will provide the specimen in a collection device provided by GDI. My DNA will be extracted from my specimen at GDI and the test will evaluate how my genome variations may lead to a higher risk for cardiac disorders. The GDI test will look for common genetic variations in genes that are important for cardiac function. The test identifies the most common variants of these genes but is not designed to identify some rare mutations which may also affect cardiac risk. The test is a clinical laboratory test and may aid in my treatment plan; therefore, I or my health insurer will be billed for this test. A written report of the test results will be provided to my health care provider who will inform me of the results. GDI will keep all of my medical information confidential and only disclose it to pursuant to applicable state and federal laws. I understand that I am responsible for providing accurate information about my insurance to Genesys Diagnostics Inc. I understand that Genesys Diagnostics Inc. will be providing testing service and billing my insurance. However, I understand that charges that are not covered by my insurance, including any applicable copayments and deductibles are my responsibility and I agree to pay such charges promptly.

Patient/Guardian Signature:* Date:*

☐ I do not consent to having my deidentified DNA sample used for internal research purposes.

Healthcare Provider Authorization

I certify that (i) this test is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law. I agree to provide Genesys, or its designee, any and all additional information reasonably required for this testing to be performed.

Healthcare Provider Signature:* Date:*

Medical Necessity Statement: Tests ordered on Medicare patients must follow CMS rules regarding medical necessity and FDA approval guidelines and must include diagnosis, symptoms and reason for testing as indicated in the medical record. If testing does not come under Medicare guidelines for payment a 'signed' Advanced Beneficiary Notice must be included.

**Certain regions in various genes have poor coverage and are not included in the panel (if you would like more coverage information regarding any specific genes of interest, please contact Genesys Diagnostics Inc.). All genes that have pseudogenes will have poorer performance on the MiSeq instrument. Variants in genes with pseudogenes may not be reliably detected. DNA alterations in regions not covered by this test such as deep intronic or regulatory regions, or in poorly covered regions will not be detected using Next Generation Sequencing analysis. There are technical limitations on the ability of Next Generation Sequencing to detect small insertions and deletions and these types of alterations are not detected as reliably as single nucleotide variants. This assay is not designed or validated for the detection of low-level mosaicism or somatic mutations.

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Patient Name_____ **Patient DOB**_____

DISEASE/CONDITION	SELF (Circle Response)	RELATIVES (Indicate Maternal or Paternal side)	AGE AT DIAGNOSIS
Irregular heartbeat	Yes / No		
Cardiac muscle thickening or thinning	Yes / No		
Amyloidosis	Yes / No		
Disease of the aorta	Yes / No		
Connective Tissue Disorder	Yes / No		
Noonan Syndrome	Yes / No		
High cholesterol	Yes / No		
Congenital heart disease	Yes / No		
Heart attack	Yes / No		
Cardiac arrest	Yes / No		
Heart transplant	Yes / No		
Hardening and narrowing of the arteries	Yes / No		
Implantable cardioverter defibrillator	Yes / No		
High blood pressure	Yes / No		
High triglycerides	Yes / No		
Fainting during exercise	Yes / No		
Fainting during normal activity	Yes / No		
Problems with exercise	Yes / No		
Sudden unexpected death without a known cause	Not applicable		
Muscle weakness or muscle disorders (such as muscular dystrophy)	Yes / No		
Any other chronic or genetic diseases that run in your family:_____	Yes / No		
Any other cardiovascular condition not mentioned above:_____	Yes / No		

PREVIOUS GENETIC TESTING

If genetic testing HAS been done please fill out table below ☐ Check here if NO genetic testing has been done

Gene:	RefSeq#:	Variant:	Genebank Reference #:
Gene:	RefSeq#:	Variant:	Genebank Reference #:
Gene:	RefSeq#:	Variant:	Genebank Reference #:
(Provide HGVS Nomenclature or indicate if other)			
Proband Name:	DOB (MM/DD/YYY):		Lab or clinic Family #:
Relationship to Patient:			

ICD-10 CODES*			
☐I49.9	Cardiac arrhythmia, unspecified.	☐I46	Cardiac arrest
☐I42.9	Cardiomyopathy, unspecified	☐Z94.1	Heart transplant status
☐E85.9	Amyloidosis, unspecified	☐I70	Atherosclerosis
☐L94.9	Localized connective tissue disorder, unspecified.	☐Z95.810	Presence of automatic (implantable) cardiac defibrillator
☐Q87.19	Other congenital malformation syndromes predominantly associated with short stature	☐I10	Hypertensive diseases
☐E78.5	Hyperlipidemia, unspecified	☐E78.1	Pure hyperglyceridemia
☐Q24.9	Congenital malformation of heart, unspecified	☐R55	Syncope and collapse
☐I21	Acute myocardial infarction		

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