GENESYS Diagnostics INC.

Developmental Delay Microarray Requisition Form

*Information required for testing

Patient Information

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

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

☐ PERIPHERAL BLOOD ☐ BUCCAL SWAB COLLECTION DATE:_____MM/DD/YYYY_____ COLLECTION TIME:_____00:00 AM/PM_____

Test(s) Requested*

☐ MICROARRAY	☐ FRAGILE X SYNDROME (FXS)	☐ CYSTIC FIBROSIS (CF)	☐ SPINAL MUSCULAR ATROPHY (SMA)	☐ DUCHENNE MUSCULAR DYSTROPHY (DMD)

☐ FISH Studies FISH STUDIES WILL NOT BE RUN UNLESS BOX IS CHECKED AND OPTIONS BELOW HAVE BEEN CHOSEN

FISH FOR ANEUPLOIDY	FISH FOR SEX CHROMOSOME ABNORMALITIES:	FISH FOR MICRODELETION SYNDROMES	
☐ (AneuVysion) X/Y/18/13/21 ☐ X/Y/18 ONLY ☐ 13/21 ONLY ☐ Trisomy 21 - Down Syndrome ☐ Trisomy 18 - Edwards Syndrome ☐ Trisomy 13 - Patau Syndrome	☐ Sex Determination (X/SRY) ☐ Turner Syndrome (CEPX/CEPY) ☐ Klinefelter Syndrome (CEPX/CEPY)	☐ Angelman syndrome (15q11-13) ☐ Cri du Chat-syndrome (5p15.2) ☐ DiGeorge/VCFS/CATCH22 (22q11.2) ☐ Kallmann syndrome (Xp22.3) ☐ Miller-Dieker syndrome (17p13.3) ☐ Prader-Willi syndrome (15q11-13) ☐ Smith-Magenis syndrome (17p 11.2)	☐ Soto syndrome (5q35) ☐ SRY (Yp11.3) ☐ Steroid Sulfatase (STS) (Xp22.3) ☐ Wolf-Hirschhorn syndrome (4p16.3) ☐ Williams Beuren syndrome (7q11.23) ☐ XIST (Xq13.2) ☐ Other_____

ICD-10 Code(s)*

☐ F70	Mild intellectual disabilities	☐ R47.89	Other speech disturbances
☐ F71	Moderate intellectual disabilities	☐ R62.0	Delayed milestone in childhood
☐ F72	Severe intellectual disabilities	☐ R62.5	Other unspecified lack of expected normal physiological development in childhood
☐ F73	Profound intellectual disabilities	☐ R62.59	Other lack of expected normal physiological development in childhood
☐ F81.81	Disorder of written expression	☐ Q18.9	Congenital malformation of face and neck, unspecified
☐ F81.89	Other developmental disorders of scholastic skills	☐ Q79.9	Congenital malformation of musculoskeletal system, unspecified
☐ F81.9	Developmental disorder of scholastic skills, unspecified	☐ Q89.7	Multiple anomalies
☐ F82	Specific developmental disorder of motor function	☐ Q89.8	Other specified congenital malformations
☐ F79	Unspecified intellectual disabilities	☐ Q89.9	Congenital malformation, unspecified
☐ F84.0	Autism spectrum disorder	☐ Z84.3	Consanguinity
☐ F88	Developmental delay	☐ Z84.89	Family history of disease or disorders
☐ F89	Unspecified Disorder of Development	☐ Other	_____
☐ K55.30	Necrotizing enterocolitis, unspecified		

Patient Authorization and Consent

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 co- payments 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.

8 Enterprise Lane Oakdale, CT 06370 Phone: (860) 574-9172 Fax: (860) 574-9264 info@gdilabs.com www.gdilabs.com CT-ST License # CL-0687

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