



A CLIA Accredited Laboratory  
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PLACE 1 BARCODE ON  
FORM AND 1 ON SAMPLE  
(REQUIRED: NAME/DOB)

CHECKLIST:		
<input type="checkbox"/> Demographics/Medication List	<input type="checkbox"/> ICD-10 Codes	<input type="checkbox"/> ABN (Medicare)
<input type="checkbox"/> Physician & Patient Signatures	<input type="checkbox"/> Copy of Patient Insurance Card	

## Neurology Test Requisition Form

First Name		Last Name		Middle Initial	Clinic Name
Social Security #	Date of Birth	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Ethnicity <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other		
Address			City	State	Zip Phone
<b>INSURANCE:</b> Please provide a legible copy of the front and back of the patient's insurance card. IF NO INSURANCE: <input type="checkbox"/> Self Pay <input type="checkbox"/> WC/Auto (Date of Injury) <input type="checkbox"/> Other					
Name of Insured		Relationship to Patient		Insurance Company/Provider	Member/ID Number Group Number
Collector Name (Print)		Date Collected		Time Collected	Fasting <input type="checkbox"/> Yes <input type="checkbox"/> No
Specimen Type <input type="checkbox"/> OCD-100 (Buccal)		Specimen Storage <input type="checkbox"/> Room Temperature <input type="checkbox"/> Refrigerated		Specimen Shipping <input type="checkbox"/> Room Temperature <input type="checkbox"/> Cooling/Ice Pack	

**MOLECULAR DIAGNOSTICS TESTING OPTIONS**  
**Neurology Genomics Test** Please select the Panel to be tested. Please attach patient Medication List.

**Neurology Comprehensive**  
 GBA, TH, PRNP, GCH1, MAPT, NOTCH3, POLG, PRKN, LRRK2, ATP13A2, ATP1A3, CSF1R, DCTN1, EIF4G1, FBXO7, HTRA2, PARK7, PINK1, PLA2G6, PRKRA, SLC6A3, SNCA, TAF1, UCHL1, VPS35 (25 genes)

**Autism Disorder**  
 AHI1, ARID1B, ASXL3, ADNP, ADSL, ARX, BCL11A, BRAF, CHD7, CHD2, CASK, CDKL5, CREBBP, GAMT, GRIN2A, MAGEL2, MECP2, NEXMIF, NSD1, PCDH19, PTEN, SCN1A, SCN2A, STXBP1, SPAST, SETD5, SLC6A1, SYNGAP1, SCN8A, SHANK3, TCF4, TBR1, VPS13B (33 genes)

**Parkinson's-Alzheimer's-Dementia**  
 GBA, PRNP, GCH1, MAPT, NOTCH3, POLG, PRKN, TH, ATP13A2, ATP1A3, CSF1R, DCTN1, EIF4G1, FBXO7, HTRA2, PARK7, PINK1, PLA2G6, PRKRA, SLC6A3, SNCA, TAF1, UCHL1, VPS35 (24 genes)

**Neurology Personal/Family History Questionnaire** Please complete Questionnaire

PATIENT'S PERSONAL HISTORY (Hx)			FAMILY HISTORY				
Clinical Details	Personal Hx	Age at Dx	Relationship	Maternal	Paternal	Cancer Site(s)	Age at Dx
Mosaicism	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>	<input type="checkbox"/>		
Consanguinity	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>	<input type="checkbox"/>		
Bone Marrow Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>	<input type="checkbox"/>		
Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>	<input type="checkbox"/>		
Known Chromosomal Gain/Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>	<input type="checkbox"/>		
Known Gene Gain/Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>	<input type="checkbox"/>		

**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

**Clinical Testing** Please indicate any clinical testing results and/or findings that may be relevant to genetic testing:  
 Karyotype  Vision  Growth Measurements  Imaging  Previous Genetic Testing  Hearing  Biochemical Testing  Pathology Results

**ICD-10 DIAGNOSIS CODES:** Additional documentation supporting Medical Necessity may be attached.

<input type="checkbox"/> F04 Amnestic Disorder Due To Known Physiological Condition	<input type="checkbox"/> F72 Severe Intellectual Disabilities
<input type="checkbox"/> F90.9 Attention-Deficit Hyperactivity Disorder, Unspecified	<input type="checkbox"/> F73 Profound Intellectual Disabilities
<input type="checkbox"/> F03.90 Unspecified Dementia Without Behavioral Disturbance	<input type="checkbox"/> F84.0 Autistic Disorder
<input type="checkbox"/> G30.9 Alzheimer's Disease, Unspecified	<input type="checkbox"/> F84.5 Asperger's Syndrome
<input type="checkbox"/> G31.01 Pick's Disease	<input type="checkbox"/> Q89.7 Multiple Congenital Malformations, Not Elsewhere Classified
<input type="checkbox"/> G31.09 Other Frontotemporal Dementia	<input type="checkbox"/> Q89.9 Congenital Malformation, Unspecified
<input type="checkbox"/> G93.7 Reye's Syndrome	<input type="checkbox"/> Q99.2 Fragile X Chromosome
<input type="checkbox"/> R41.0 Disorientation, Unspecified	<input type="checkbox"/> R62.0 Delayed Milestone In Childhood
<input type="checkbox"/> R41.3 Other Amnesia	<input type="checkbox"/> E70.1 Other Hyperphenylalaninemias
<input type="checkbox"/> R47.01 Aphasia	<input type="checkbox"/> E72.04 Cystinosis
<input type="checkbox"/> R48.1 Agnosia	<input type="checkbox"/> E75.02 Tay-Sachs Disease
<input type="checkbox"/> R48.2 Apraxia	<input type="checkbox"/> E75.249 Niemann-Pick Disease, Unspecified
<input type="checkbox"/> G45.9 Transient Cerebral Ischemic Attack, Unspecified	<input type="checkbox"/> E83.01 Wilson's Disease
<input type="checkbox"/> I63.91 Cerebral Infarction, Unspecified	<input type="checkbox"/> G43.001 Migraine Without Aura, Not Intractable, With Status Migrainosus
<input type="checkbox"/> G52.91 Cranial Nerve Disorder, Unspecified	<input type="checkbox"/> G43.011 Migraine Without Aura, Intractable, With Status Migrainosus tissue
<input type="checkbox"/> E72.01 Cystinuria	<input type="checkbox"/> Other

**Medical Necessity** Required for insurance  I, the provider, attest that I am the ordering physician or am authorized under applicable laws and regulations to order genetic testing for the patient. I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder, and that the results will be used in medical management and care decisions for the patient. I further attest that any information entered on this Test Requisition Form, or otherwise provided by me on behalf of the patient, is true and correct to the best of my knowledge, and that the patient has consented to receive communications about his/her genetic test from RDL.

**Patient Informed Consent** Patient must consent  I, the patient, voluntarily consent to the collection and testing of my specimen. I certify that the specimen is fresh and has not been adulterated in any manner. I authorize the laboratory to release the results of this testing to the ordering provider. I further authorize my insurance benefits to be paid directly to RDL for services rendered. I acknowledge that the lab may be treated as an out-of-network provider. In the event I receive payment for laboratory services from my insurer, I will remit said payment to the lab within 14 days of receipt. I will either endorse the original check, or produce a personal check for the entire payment amount, and forward it to the lab. When selecting Self Pay above, I acknowledge financial responsibility for all lab charges associated with the processing of this test requisition. All rights to the samples will belong to the laboratory conducting the testing. There will be no compensation in the event of an invention resulting from research and development using this sample. I agree to allow my provided specimen to be used for the purpose of (diagnosis/research) (development/quality control). I understand that if I agree, any information identifying me will be kept confidential so that it will not be possible to determine from whom the sample was drawn. Your signature on this form indicates that you understand to your satisfaction the information about RDL and agree to have the test done. In no way does this waive your legal rights or release anyone from their legal and professional responsibilities. If you have further questions concerning matters related to this consent, you may wish to seek professional genetic counseling prior to signing this form. Consultation with a medical geneticist, genetic counselor, or your referring healthcare provider also may be warranted after the test has been completed.

**Opt In for Research**  I give permission for my specimen and clinical information to be used in de-identified studies at Tesis Biosciences and for publication, if Tesis deems it appropriate. I understand that my name and/or other identifying information will NOT be used in or linked to the results of any studies and publications. More information is available at www.tesisbiosciences.com.

Provider Name (Print)	Provider NPI #	Clinic Address	Clinic Phone/Fax
Provider Signature	Date	Patient Signature (or Legal Guardian)	Date
X		X	