

Curated Multigene Panel TRF

Please complete every field and tick box clearly.

PATIENT INFORMATION

Patient's First Name Middle Initial Patient's Date of Birth

Patient's Last Name Patient ID/MR Number

Biological Sex: Male Female Unknown
 Gender Identity (if different from above):

Patient's Street Address

City / Town State Zip Code

Country Patient's Preferred Phone

Patient's Email

Ethnicity (check all that apply): African-American Asian (China, Japan, Korea)
 Caucasian/N. European/S. European Finnish French Canadian
 Hispanic Jewish - Ashkenazi Jewish - Sephardic Mediterranean
 Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey) Native American E. Indian
 Southeast Asian (Vietnam, Cambodia, Thailand) South Asian (India, Pakistan)
 Other (specify)

ORDERING PROVIDER

Provider's First and Last Name

PKIG Ordering Provider Account Number NPI

Clinic/Hospital/Institution Name

Provider's Email Provider's Phone

Provider's Street Address

City / Town State Zip Code

Country Provider's Fax

SEND ADDITIONAL COPY OF RESULTS TO (If applicable)

Name

PKIG Ordering Provider Account Number Phone Number

Email Address Fax Number

PHYSICIAN CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate informed consent for the testing ordered, including a discussion of the benefits and limitations. I confirm that testing is medically necessary and that test results may impact medical management for the patient. I understand and agree that, if the patient's insurance requires genetic counseling prior to performance of the ordered test, PerkinElmer will provide the patient information to a third party service so the patient can obtain genetic counseling. I understand and agree that a genetic counselor will be permitted to review the test(s) I have ordered and make changes based on clinical or payor related specifications, and that the genetic counselor will submit to the payor the required documentation in support of the test as ordered or with any recommended changes. I attest that all information on this TRF is true to the best of my knowledge. My signature applies to the entirety of the statement above and/or attached letter of medical necessity.

Signature _____ Date _____

PATIENT SAMPLE INFORMATION

SAMPLE TYPE: Saliva Swab Whole Blood Dried Blood Spots Other _____
 Collection Date:
 Was this sample collected in NY State: yes no

INDICATION FOR TESTING (Required)

ICD10 Code(s): _____
 Clinical Diagnosis: _____
 Age at Initial Presentation: _____

TEST MENU

Curated panel by clinical indication
 Choose any of our multigene disease-specific next-generation sequencing panels (no reflex options). Clinical indications include neuromuscular, neurology, cardiology, hereditary cancer, and other categories such as hearing loss and ophthalmology. Log into ordering portal to select the correct panel at <https://client.perkinelmergenomics.com/login/>

TO ORDER ON PAPER:

Provide test code here: _____
 Provide test name here: _____

Please note: STAT test codes are not billable to insurance.

D3000 AnyPanel™ Test
 Custom exome-based panel (with reflex options). Gene total may range from 2 to 1,000 genes; if larger, whole exome sequencing is more efficient. Please submit custom requested gene list for testing at apps.perkinelmergenomics.com/genelist, and include custom panel ID below.

PROVIDE CUSTOM PANEL ID HERE: _____

FOR INTERNAL USE ONLY

Date Rec'd	_____	Rec'd	_____
TEMP	SPEC	COL	#TUBES VOL
R/C/F			
R/C/F			
R/C/F			

■ INSURANCE BILLING (Include a copy of both sides of insurance card)

<input type="text"/>	<input type="text"/>
Insurance Carrier	Insurance ID
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>
Policy Holder Name	Policy Holder DOB
Policy Holder Relationship to Patient: <input type="radio"/> Self <input type="radio"/> Parent <input type="radio"/> Spouse <input type="radio"/> Other: _____	

Benefit Investigation and Out-of-Pocket Cost Policy

PerkinElmer will contact the patient for any estimated out-of-pocket costs that are greater than \$100 USD before proceeding with testing. The patient's sample will be placed on hold (for up to 30 days) until authorization to proceed is received from the patient. If the patient does not respond to PerkinElmer within 30 days to discuss estimated out-of-pocket costs, the test order may be cancelled. Please note that failure by the patient to respond to PerkinElmer in a timely fashion regarding estimated out-of-pocket costs may cause a delay in the receipt of the results report.

Patient Billing Acknowledgement:

By signing this form, I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I hereby authorize PerkinElmer Genetics, Inc. ("PerkinElmer") to bill my designated insurance carrier(s) and share health information as needed for the purposes of billing and reimbursement, and I request that payment of authorized benefits be made on my behalf to PerkinElmer for any services furnished the patient listed above by PerkinElmer. If any insurance benefits are remitted to me for services performed by PerkinElmer for the patient, I will forward said benefits to PerkinElmer. I authorize PerkinElmer to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I agree to pay all charges for services provided by PerkinElmer to the patient which are not covered by my health insurance plan or which I am responsible for payment under my health insurance plan. Furthermore, I grant PerkinElmer permission to share health information with my insurance as needed for the purposes of billing and reimbursement.

Signature _____ Date _____

Please note: STAT test codes are not billable to insurance.

■ INSTITUTIONAL BILLING

<input type="text"/>	<input type="text"/>
Institution/Organization Name	PerkinElmer Genomics Billing Account ID
<input type="text"/>	<input type="text"/>
Contact Name	Contact Phone

■ PATIENT BILLING

Check: \$ _____ Amount Enclosed (Please make checks payable to: PerkinElmer Genetics, Inc.)

Credit Card (Please fill out all information):

<input type="text"/>	<input type="text"/>
Credit Card Number	CVV
<input type="text"/>	<input type="text" value="MM/YY"/>
Credit Card Billing Street Address	Card Exp. Date Cardholder Phone
<input type="text"/>	<input type="text"/>
City / Town State Zip Code	Cardholder Printed Name as Appears on Card
<input type="text"/>	
Cardholder Signature	

Detailed medical records, clinical summary, pictures, and family history must be attached for all cases if you would like a phenotypically driven report.
Such information is crucial for the accurate interpretation of results.

ADDITIONAL OPTIONAL PHENOTYPE / PATIENT HISTORY SECTION (Check all that apply)

Clinical diagnosis: _____

Age of manifestation: _____ ICD-10 Codes: _____

<p>A. NEUROLOGY</p> <p>1. Behavioral abnormality</p> <p><input type="radio"/> 1.1 Autism</p> <p><input type="radio"/> 1.2 Attention deficit disorder</p> <p><input type="radio"/> 1.3 Psychiatric diseases</p> <p>2. Brain imaging</p> <p><input type="radio"/> 2.1 Abnormal myelination</p> <p><input type="radio"/> 2.2 Abnormal cortical gyration</p> <p><input type="radio"/> 2.3 Agenesis of corpus callosum</p> <p><input type="radio"/> 2.4 Brain atrophy</p> <p><input type="radio"/> 2.5 Cerebellar hypoplasia</p> <p><input type="radio"/> 2.6 Heterotopia</p> <p><input type="radio"/> 2.7 Holoprosencephaly</p> <p><input type="radio"/> 2.8 Hydrocephalus</p> <p><input type="radio"/> 2.9 Leukodystrophy</p> <p><input type="radio"/> 2.10 Lissencephaly</p> <p>3. Developmental delay</p> <p><input type="radio"/> 3.1 Delayed motor development</p> <p><input type="radio"/> 3.2 Delayed language development</p> <p><input type="radio"/> 3.3 Developmental regression</p> <p><input type="radio"/> 3.4 Intellectual disability</p> <p>4. Movement abnormality</p> <p><input type="radio"/> 4.1 Ataxia</p> <p><input type="radio"/> 4.2 Chorea</p> <p><input type="radio"/> 4.3 Dystonia</p> <p><input type="radio"/> 4.4 Parkinsonism</p> <p>5. Neuromuscular abnormality</p> <p><input type="radio"/> 5.1 Muscular hypotonia</p> <p><input type="radio"/> 5.2 Muscular hypertonia</p> <p><input type="radio"/> 5.3 Hyperreflexia</p> <p><input type="radio"/> 5.4 Spasticity</p> <p>6. Seizures</p> <p><input type="radio"/> 6.1 Febrile seizures</p> <p><input type="radio"/> 6.2 Focal seizures</p> <p><input type="radio"/> 6.3 Generalized seizures</p> <p>7. Others</p> <p><input type="radio"/> 7.1 Craniosynostosis</p> <p><input type="radio"/> 7.2 Dementia</p> <p><input type="radio"/> 7.3 Encephalopathy</p> <p><input type="radio"/> 7.4 Headache / Migraine</p> <p><input type="radio"/> 7.5 Macrocephaly</p> <p><input type="radio"/> 7.6 Microcephaly</p> <p><input type="radio"/> 7.7 Neuropathy</p> <p><input type="radio"/> 7.8 Stroke</p>	<p>B. METABOLISM</p> <p><input type="radio"/> 1. Abnormal creatine kinase</p> <p><input type="radio"/> 2. Decreased plasma carnitine</p> <p><input type="radio"/> 3. Hyperalaninemia</p> <p><input type="radio"/> 4. Hypoglycemia</p> <p><input type="radio"/> 5. Increased CSF lactate</p> <p><input type="radio"/> 6. Increased serum pyruvate</p> <p><input type="radio"/> 7. Ketosis</p> <p><input type="radio"/> 8. Lactic acidosis</p> <p><input type="radio"/> 9. Organic aciduria</p> <p>C. EYE</p> <p><input type="radio"/> 1. Blepharospasm</p> <p><input type="radio"/> 2. Cataract</p> <p><input type="radio"/> 3. Coloboma</p> <p><input type="radio"/> 4. Glaucoma</p> <p><input type="radio"/> 5. Microphthalmos</p> <p><input type="radio"/> 6. Nystagmus</p> <p><input type="radio"/> 7. Ophthalmoplegia</p> <p><input type="radio"/> 8. Optic atrophy</p> <p><input type="radio"/> 9. Ptosis</p> <p><input type="radio"/> 10. Retinitis pigmentosa</p> <p><input type="radio"/> 11. Retinoblastoma</p> <p><input type="radio"/> 12. Strabismus</p> <p><input type="radio"/> 13. Visual impairment</p> <p>D. MOUTH, THROAT AND EAR</p> <p><input type="radio"/> 1. Abnormality of dental color</p> <p><input type="radio"/> 2. Cleft lip / palate</p> <p><input type="radio"/> 3. Conductive hearing impair.</p> <p><input type="radio"/> 4. External ear malformation</p> <p><input type="radio"/> 5. Hypodontia</p> <p><input type="radio"/> 6. Sensoneural hearing impair.</p> <p>E. SKIN, INTEGUMENT AND SKELETAL</p> <p>1. Skeletal</p> <p><input type="radio"/> 1.1 Abnormal limb morphology</p> <p><input type="radio"/> 1.2 Abnormal skeletal system</p> <p><input type="radio"/> 1.3 Abnormal vertebral column</p> <p><input type="radio"/> 1.4 Joint hypermobility</p> <p><input type="radio"/> 1.5 Multiple joint contractures</p> <p><input type="radio"/> 1.6 Polydactyly</p> <p><input type="radio"/> 1.7 Scoliosis</p> <p><input type="radio"/> 1.8 Syndactyly</p> <p><input type="radio"/> 1.9 Talipes equinovarus</p>	<p>2. Skin and integument</p> <p><input type="radio"/> 2.1 Abnormal skin pigmentation</p> <p><input type="radio"/> 2.2 Abnormal hair</p> <p><input type="radio"/> 2.3 Abnormal nail</p> <p><input type="radio"/> 2.4 Hyperextensible skin</p> <p><input type="radio"/> 2.5 Ichthyosis</p> <p>F. CARDIOVASCULAR</p> <p><input type="radio"/> 1. Angioedema</p> <p><input type="radio"/> 2. Aortic dilatation</p> <p><input type="radio"/> 3. Arrhythmia</p> <p><input type="radio"/> 4. Coarctation of aorta</p> <p><input type="radio"/> 5. Defect of atrial septum</p> <p><input type="radio"/> 6. Defect of ventricular septum</p> <p><input type="radio"/> 7. Dilated cardiomyopathy</p> <p><input type="radio"/> 8. Hypertension</p> <p><input type="radio"/> 9. Hypertrophic cardiomyopathy</p> <p><input type="radio"/> 10. Hypotension</p> <p><input type="radio"/> 11. Lymphedema</p> <p><input type="radio"/> 12. Malf. of heart and great vessels</p> <p><input type="radio"/> 13. Myocardial infarction</p> <p><input type="radio"/> 14. Stroke</p> <p><input type="radio"/> 15. Tetralogy of Fallot</p> <p><input type="radio"/> 16. Vasculitis</p> <p>G. GASTROINTESTINAL, GENITOURINARY, ENDOCRINE</p> <p>1. Gastrointestinal</p> <p><input type="radio"/> 1.1 Aganglionic megacolon</p> <p><input type="radio"/> 1.2 Constipation</p> <p><input type="radio"/> 1.3 Diarrhea</p> <p><input type="radio"/> 1.4 High hepatic transaminases</p> <p><input type="radio"/> 1.5 Gastroschisis</p> <p><input type="radio"/> 1.6 Hepatic failure</p> <p><input type="radio"/> 1.7 Hepatomegaly</p> <p><input type="radio"/> 1.8 Obesity</p> <p><input type="radio"/> 1.9 Pyloric stenosis</p> <p><input type="radio"/> 1.10 Vomiting</p> <p>2. Genitourinary</p> <p><input type="radio"/> 2.1 Abnormal renal morphology</p> <p><input type="radio"/> 2.2 Abnormal urinary system</p> <p><input type="radio"/> 2.3 Hydronephrosis</p> <p><input type="radio"/> 2.4 Renal agenesis</p> <p><input type="radio"/> 2.5 Renal cyst</p> <p><input type="radio"/> 2.6 Renal tubular dysfunction</p>	<p>3. Endocrine</p> <p><input type="radio"/> 3.1 Diabetes mellitus</p> <p><input type="radio"/> 3.2 Hypo / hyperparathyroidism</p> <p><input type="radio"/> 3.3 Hypo / hyperthyroidism</p> <p>H. REPRODUCTION</p> <p><input type="radio"/> 1. Abnormal external genitalia</p> <p><input type="radio"/> 2. Abnormal internal genitalia</p> <p><input type="radio"/> 3. Hypogonadism</p> <p><input type="radio"/> 4. Hypospadias</p> <p><input type="radio"/> 5. Infertility</p> <p>I. ONCOLOGY</p> <p><input type="radio"/> 1. Adenomatous polyposis</p> <p><input type="radio"/> 2. Breast carcinoma</p> <p><input type="radio"/> 3. Colorectal carcinoma</p> <p><input type="radio"/> 4. Leukemia</p> <p><input type="radio"/> 5. Myelofibrosis</p> <p><input type="radio"/> 6. Neoplasm of the lung</p> <p><input type="radio"/> 7. Neoplasm of the skin</p> <p><input type="radio"/> 8. Paraganglioma</p> <p><input type="radio"/> 9. Pheochromocytoma</p> <p>J. HEMATOLOGY AND IMMUNOLOGY</p> <p><input type="radio"/> 1. Abnormality of coagulation</p> <p><input type="radio"/> 2. Anemia</p> <p><input type="radio"/> 3. Immunodeficiency</p> <p><input type="radio"/> 4. Neutropenia</p> <p><input type="radio"/> 5. Pancytopenia</p> <p><input type="radio"/> 6. Abnormal hemoglobin</p> <p><input type="radio"/> 7. Splenomegaly</p> <p><input type="radio"/> 8. Thrombocytopenia</p> <p>K. PRENATAL AND DEVELOPMENT</p> <p><input type="radio"/> 1. Dysmorphic facial features</p> <p><input type="radio"/> 2. Failure to thrive</p> <p><input type="radio"/> 3. Hemihypertrophy</p> <p><input type="radio"/> 4. Hydrops fetalis</p> <p><input type="radio"/> 5. IUGR</p> <p><input type="radio"/> 6. Oligohydramnios</p> <p><input type="radio"/> 7. Overgrowth</p> <p><input type="radio"/> 8. Polyhydramnios</p> <p><input type="radio"/> 9. Premature birth</p> <p><input type="radio"/> 10. Short stature</p> <p><input type="radio"/> 11. Tall stature</p>
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OTHER: _____