PerkinElmer For the Better | PerkinElmer GENOMICS

STAT Testing Requisition Form

Please complete every field and tick box clearly.

PATIENT INFORMATION

Patient's First Name | Middle Initial | Patient's Date of Birth MM/ DD /YYYY

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

PATIENT SAMPLE INFORMATION

SAMPLE TYPE:
○ Saliva Swab
○ Whole Blood
○ Dried Blood Spots
Other______

Collection Date: MM/DD/YY

Was this sample collected in NY State: ○ yes ○ no

INDICATION FOR TESTING (Required)

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

TEST MENU

○ **STAT 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:
Test code:______F______
Test name: ______

STAT Whole Exome Sequencing Testing Options
○ D1010 STAT Exome – Proband Only
○ D1310 STAT Exome – TRIO (Proband Report Only)*
○ D1311 STAT Exome – TRIO (Proband and Family Member Reports)*

STAT Whole Genome Sequencing Testing Options
○ D2010 STAT Genome – Proband Only
○ D2310 STAT Genome – TRIO (Proband Report Only)*
○ D2311 STAT Genome – TRIO (Proband and Family Member Reports)*

STAT Custom Panel
○ D3000S AnyPanel™: Custom Panel
Please submit custom requested gene list for testing at apps.perkinelmergenomics.com/genelist, and **include custom panel ID below**

PROVIDE CUSTOM PANEL ID HERE:

Other STAT Testing Options Note: Please use STAT Prenatal Testing Requisition for prenatal samples.
Test code: ______F______
Test name:______

! * Please fill out family member section below. **Additional samples MUST be received within 3 weeks.**

FAMILIAL INFORMATION (Required with ALL TRIO orders)

FAMILY MEMBER 1:
Last name, First name
Date of Birth: MM/DD/YYYY Relation to Proband:______
Symptomatic (clinically affected)? ○ yes ○ no
Sample: ○ Included - Collection Date MM/DD/YY ○ To be sent later

FAMILY MEMBER 2:
Last name, First name
Date of Birth: MM/DD/YYYY Relation to Proband:______
Symptomatic (clinically affected)? ○ yes ○ no
Sample: ○ Included - Collection Date MM/DD/YY ○ To be sent later

PHYSICIAN CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The undersigned person (or representative thereof) certifies 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. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the informed consent and/or attached letter of medical necessity.

Signature______ Date______

FOR INTERNAL USE ONLY				
Date Rec'd______	Rec'd ______			
TEMP	SPEC	COL	#TUBES	VOL
R/C/F				
R/C/F				
R/C/F				

250 Industry Drive, Pittsburgh, PA 15275
T 866-354-2910 • F 412-220-0785 • genomics@perkinelmer.com

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STAT Testing Requisition Form

■ INSTITUTIONAL BILLING

Institution/Organization Name

PerkinElmer Genomics Billing Account ID

Contact Name

Contact Phone

■ PATIENT BILLING

○ **Check:** $___________ Amount Enclosed (Please make checks payable to: PerkinElmer Genetics, Inc.)

○ **Credit Card** (Please fill out all information):

Credit Card Number

CVV

Credit Card Billing Street Address

MM/YY

Card Exp. Date

Cardholder Phone

City / Town

State

Zip Code

Cardholder Printed Name as Appears on Card

Cardholder Signature

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STAT Testing Requisition Form

DETAILED MEDICAL RECORDS, CLINICAL SUMMARY, PICTURES AND FAMILY HISTORY MUST BE ATTACHED FOR ALL CASES.
CLINICAL INFORMATION IS CRUCIAL FOR ACCURATE INTERPRETATION OF RESULTS.

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

Clinical diagnosis: ______________________________

Age of manifestation: ______________________________ ICD-10 Codes: ____________________

A. NEUROLOGY

1. Behavioral abnormality

- ○ 1.1 Autism
- ○ 1.2 Attention deficit disorder
- ○ 1.3 Psychiatric diseases

2. Brain imaging

- ○ 2.1 Abnormal myelination
- ○ 2.2 Abnormal cortical gyration
- ○ 2.3 Agenesis of corpus callosum
- ○ 2.4 Brain atrophy
- ○ 2.5 Cerebellar hypoplasia
- ○ 2.6 Heterotopia
- ○ 2.7 Holoprosencephaly
- ○ 2.8 Hydrocephalus
- ○ 2.9 Leukodystrophy
- ○ 2.10 Lissencephaly

3. Developmental delay

- ○ 3.1 Delayed motor development
- ○ 3.2 Delayed language development
- ○ 3.3 Developmental regression
- ○ 3.4 Intellectual disability

4. Movement abnormality

- ○ 4.1 Ataxia
- ○ 4.2 Chorea
- ○ 4.3 Dystonia
- ○ 4.4 Parkinsonism

5. Neuromuscular abnormality

- ○ 5.1 Muscular hypotonia
- ○ 5.2 Muscular hypertonia
- ○ 5.3 Hyperreflexia
- ○ 5.4 Spasticity

6. Seizures

- ○ 6.1 Febrile seizures
- ○ 6.2 Focal seizures
- ○ 6.3 Generalized seizures

7. Others

- ○ 7.1 Craniosynostosis
- ○ 7.2 Dementia
- ○ 7.3 Encephalopathy
- ○ 7.4 Headache / Migraine
- ○ 7.5 Macrocephaly
- ○ 7.6 Microcephaly
- ○ 7.7 Neuropathy
- ○ 7.8 Stroke

B. METABOLISM

- ○ 1. Abnormal creatine kinase
- ○ 2. Decreased plasma carnitine
- ○ 3. Hyperalaninemia
- ○ 4. Hypoglycemia
- ○ 5. Increased CSF lactate
- ○ 6. Increased serum pyruvate
- ○ 7. Ketosis
- ○ 8. Lactic acidosis
- ○ 9. Organic aciduria

C. EYE

- ○ 1. Blepharospasm
- ○ 2. Cataract
- ○ 3. Coloboma
- ○ 4. Glaucoma
- ○ 5. Microphthalmos
- ○ 6. Nystagmus
- ○ 7. Ophthalmoplegia
- ○ 8. Optic atrophy
- ○ 9. Ptosis
- ○ 10. Retinitis pigmentosa
- ○ 11. Retinoblastoma
- ○ 12. Strabismus
- ○ 13. Visual impairment

D. MOUTH, THROAT AND EAR

- ○ 1. Abnormality of dental color
- ○ 2. Cleft lip / palate
- ○ 3. Conductive hearing impair.
- ○ 4. External ear malformation
- ○ 5. Hypodontia
- ○ 6. Sensoneural hearing impair.

E. SKIN, INTEGUMENT AND SKELETAL

1. Skeletal

- ○ 1.1 Abnormal limb morphology
- ○ 1.2 Abnormal skeletal system
- ○ 1.3 Abnormal vertebral column
- ○ 1.4 Joint hypermobility
- ○ 1.5 Multiple joint contractures
- ○ 1.6 Polydactyly
- ○ 1.7 Scoliosis
- ○ 1.8 Syndactyly
- ○ 1.9 Talipes equinovarus

2. Skin and integument

- ○ 2.1 Abnormal skin pigmentation
- ○ 2.2 Abnormal hair
- ○ 2.3 Abnormal nail
- ○ 2.4 Hyperextensible skin
- ○ 2.5 Ichthyosis

F. CARDIOVASCULAR

- ○ 1. Angioedema
- ○ 2. Aortic dilatation
- ○ 3. Arrhythmia
- ○ 4. Coarctation of aorta
- ○ 5. Defect of atrial septum
- ○ 6. Defect of ventricular septum
- ○ 7. Dilated cardiomyopathy
- ○ 8. Hypertension
- ○ 9. Hypertrophic cardiomyopathy
- ○ 10. Hypotension
- ○ 11. Lymphedema
- ○ 12. Malf. of heart and great vessels
- ○ 13. Myocardial infarction
- ○ 14. Stroke
- ○ 15. Tetralogy of Fallot
- ○ 16. Vasculitis

G. GASTROINTESTINAL, GENITOURINARY, ENDOCRINE

1. Gastrointestinal

- ○ 1.1 Aganglionic megacolon
- ○ 1.2 Constipation
- ○ 1.3 Diarrhea
- ○ 1.4 High hepatic transaminases
- ○ 1.5 Gastroschisis
- ○ 1.6 Hepatic failure
- ○ 1.7 Hepatomegaly
- ○ 1.8 Obesity
- ○ 1.9 Pyloric stenosis
- ○ 1.10 Vomiting

2. Genitourinary

- ○ 2.1 Abnormal renal morphology
- ○ 2.2 Abnormal urinary system
- ○ 2.3 Hydronephrosis
- ○ 2.4 Renal agenesis
- ○ 2.5 Renal cyst
- ○ 2.6 Renal tubular dysfunction

3. Endocrine

- ○ 3.1 Diabetes mellitus
- ○ 3.2 Hypo / hyperparathyroidism
- ○ 3.3 Hypo / hyperthyroidism

H. REPRODUCTION

- ○ 1. Abnormal external genitalia
- ○ 2. Abnormal internal genitalia
- ○ 3. Hypogonadism
- ○ 4. Hypospadias
- ○ 5. Infertility

I. ONCOLOGY

- ○ 1. Adenomatous polyposis
- ○ 2. Breast carcinoma
- ○ 3. Colorectal carcinoma
- ○ 4. Leukemia
- ○ 5. Myelofibrosis
- ○ 6. Neoplasm of the lung
- ○ 7. Neoplasm of the skin
- ○ 8. Paraganglioma
- ○ 9. Pheochromocytoma

J. HEMATOLOGY AND IMMUNOLOGY

- ○ 1. Abnormality of coagulation
- ○ 2. Anemia
- ○ 3. Immunodeficiency
- ○ 4. Neutropenia
- ○ 5. Pancytopenia
- ○ 6. Abnormal hemoglobin
- ○ 7. Splenomegaly
- ○ 8. Thrombocytopenia

K. PRENATAL AND DEVELOPMENT

- ○ 1. Dysmorphic facial features
- ○ 2. Failure to thrive
- ○ 3. Hemihypertrophy
- ○ 4. Hydrops fetalis
- ○ 5. IUGR
- ○ 6. Oligohydramnios
- ○ 7. Overgrowth
- ○ 8. Polyhydramnios
- ○ 9. Premature birth
- ○ 10. Short stature
- ○ 11. Tall stature

OTHER:

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