Washington University Physicians®

SEQUENCING: MOSAICISM DISORDERS

Sample shipping address:

Washington University Department of Pathology & Immunology
Clinical Support Office
425 S. Euclid Ave. | MSC 8024-14-4711 | St. Louis MO 63110
Tel: (314) 747-7337 | Fax: (314) 747-7336

Sample drop-off locations:

Children's Hospital
One Children's Place
Central Receiving 2N-25
St. Louis, MO 63110
Tel: (314) 454-4161

North Campus Lab
Institute of Health (IOH) Core Lab
425 S. Euclid Ave. | Room 4701
St. Louis, MO 63110
Tel: (314) 362-1470

This requisition has two pages, please complete both pages to ensure testing.

PATIENT IDENTIFICATION

Patient Status: ☐ Inpatient ☐ Outpatient ☐ Office Visit

Name Last:	First:	MI:
DOB (mm/dd/yyyy):	Sex: ☐ Male ☐ Female	
Medical Record # (if applicable):		
Address:		
City:	State:	Zip:

Ethnicity (select all that apply)

☐ African American ☐ Asian ☐ Caucasian/NW European
☐ E Indian ☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic
☐ Mediterranean ☐ Native Hawaiian/Pacific Islander ☐ Other

PHYSICIAN ORDERING TEST (NPI required)

Name:		
Institution:		
NPI:	Email:	
Address:		
City:	State:	Zip:
Phone:	Fax:	
Alternative Contact Information:		
Phone:	Email:	
Notes:		

SPECIMEN TYPE

☐ Testing from Archival Specimen(s): (prior biopsies)
☐ Previous Pathology Case Number:
For samples located outside of BJH submit: (1) Signed Patient Release for Surgical Material Form & (2) Pathology Report
☐ New Specimen(s)

PRIMARY SAMPLE TYPE (required to select one)

☐ Formalin-fixed paraffin embedded tissue ☐ Fresh Tissue (culture/transport media)
☐ Buccal Swab (contact us before sending) ☐ Other:

Date Collected (mm/dd/yyyy):	Time:
Collected By:	Sample Source:

SECONDARY SAMPLE TYPE

☐ Peripheral Blood (recommended in addition to primary sample for comparative analysis)
☐ Other

Date Collected (mm/dd/yyyy):	Time:
Collected By:	

REASON FOR TESTING (Required-failure to include diagnosis may delay testing)

Diagnosis:

ICD10 Code(s):

TESTING REQUESTED

All tests include next-generation sequencing of the coding exons of listed genes to detect single nucleotide variants and small insertions and deletions. Focused analysis includes the genes in the focused panel only. Comprehensive analysis is performed in two stages: 1) initial analysis of the focused subset only. Identification of clinically significant (pathogenic or likely pathogenic) variants precludes further analysis and a final report is issued; 2) if no pathogenic/likely pathogenic variants are identified in the focused panel, additional genes from the larger Mosaicism Disorders Gene Panel are analyzed and variants from these genes are reviewed and classified. For all reported variants, evidence for an association with the patient's indicated phenotype is documented in the variant interpretation section for any reported variant.

Please see website (gps.wustl.edu) for gene lists and details on the ordering of focused versus comprehensive gene panels.

Somatic Overgrowth Panel with interpretation
☐ Focused 25 genes ☐ Comprehensive 37 genes

Rasopathies Panel with interpretation
☐ Focused 14 genes ☐ Comprehensive 37 genes

Nevus Panel with interpretation
☐ Focused 12 genes ☐ Comprehensive 37 genes

Maffucci Syndrome Panel with interpretation
☐ Focused 2 genes ☐ Comprehensive 37 genes

***PIK3CA*-Related Overgrowth Spectrum Disorders with interpretation**
☐ Focused 1 gene ☐ Comprehensive 37 genes

McCune Albright Syndrome with interpretation
☐ Focused 1 gene ☐ Comprehensive 37 genes

Curry-Jones Syndrome with interpretation
☐ Focused 1 gene ☐ Comprehensive 37 genes

Custom Panel with interpretation (Please indicate custom request in the additional notes section below)
☐ Focused-only custom genes listed below ☐ Comprehensive 37 genes

☐ **Targeted testing for known familial gene variant**	Gene:	Variant:
Please include copy of proband report		Relationship to patient above:

ADDITIONAL NOTES:

Healthcare Professional Signature to Authorize Testing, Statement of Medical Necessity and Transmission of Results Verification I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

The undersigned Client authorizes the Washington University School of Medicine to send Protected Healthcare Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number above. Client acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.

Signature:	Date:

Below, office use only:

Date/Time Received:	Accession Number:	Technician Initial:

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):

INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at (314) 362-5641 or via email at path-billing@email.wustl.edu for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):
CPT Codes and Units Authorized:	

ATTACH COPY OF INSURANCE CARD (if not available, complete the following)

Policy Holder's Name: Last First MI	Insurance Co. Name:	
	Insurance Co. Phone:	
Policy Holder's Date of Birth (mm/dd/yyyy):	Plan Name:	
Relationship to patient:	ID#:	Group#:

SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our Patient Accounts Manager office at (314) 362-5641 or via email at path-billing@email.wustl.edu.

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

Institution Name:		
Contact Name:		
Email:		
Billing Address:		
City:	State:	Zip:
Phone:	Fax:	