GeneStreet Laboratories

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genestreet.com

Alzheimer Dementia Parkinson Test Requisition

1. PATIENT INFORMATION (REQUIRED)

First Name_____ Last Name_____
Date of Birth (mm/dd/yyyy) _____ ☐Female ☐Male Age____
Address_____
City_____ State_____ Zip Code _____
Phone _____ Email_____

2. PATIENT PAYMENT OPTIONS

☐ **INSURANCE:** Please attach a copy of front and back of insurance card and
☐ **SELF-PAY:** GeneStreet will contact patient to obtain payment
☐ **INVOICE PRACTICE / INSTITUITIONAL BILL / FACILITY BILL**

3. ORDERING PHYSICIAN INFORMATION (REQUIRED)

First Name_____ Last Name_____
Medical Credentials_____ NPI#_____
Facility Name_____
Address_____
City_____ State_____ Zip_____
Direct Office Contact_____
Phone_____

4. SPECIMEN INFORMATION (REQUIRED)

Date of Collection_____ Collected By_____

Specimen Type **X** Oral Buccal Swab

5. TEST(S) REQUESTED

☐ **Early Onset Alzheimer Disease (EOAD)** **3 Genes** APP, PSEN1, PSEN2

☐ **Late Onset Alzheimer Disease (LOAD)** **39 Genes**

☐ **Late Onset Alzheimer Disease** APOE ε4

☐ **Parkinson-Alzheimer-Dementia** **39 Genes** A2M, AAAS, ACE, APOE, APP, ATP13A2, ATP1A3, C9orf72, CSF1R, DCTN1, DNMT1, EIF4G1, FBXO7, GBA, GCH1, GRN, HTRA2, LRRK2, MAPT, MPO, NOTCH3, PARK7, PINK1, PLA2G6, POLG, PRKN, PRKRA, PRNP, PSEN1, PSEN2, SLC6A3, SNCA, SNCB, TAF1, TH, TREM2, TYROBP, UCHL1, VPS35

☐ **Alzheimer-Dementia** **16 Genes** APOE, APP, C9orf72, CSF1R, DNMT1, EIF4G1, GBA, GRN, MAPT, PRNP, PSEN1, PSEN2, SNCA, SNCB, TREM2, TYROBP

☐ **Parkinson** **26 Genes** ATP13A2, ATP1A3, CSF1R, DCTN1, EIF4G1, FBXO7, GBA, GCH1, GRN, HTRA2, LRRK2, MAPT, MPO, NOTCH3, PARK7, PINK1, PLA2G6, POLG, PRKN, PRKRA, PRNP, SLC6A3, SNCA, TAF1, TH, UCHL1, VPS35

☐ **Custom Gene(s)** _____

DUO/TRIO (requires additional information and consent for testing, see Page 2), repeat expansion, known mutation(s), hold samples, additional report delivery. The lab may perform confirmation of parental relationships for quality control or other purposes. See the attached informed consent for more details.

☐ Check here to opt-out

6. INDICATIONS FOR TESTING	7. ICD10 CODE(S)
☐ Presymptomatic	☐ G30.0 – Alzheimer's disease with early onset
☐ Family History	☐ G30.1 – Alzheimer's disease with late onset
☐ Family Variant	☐ G30.8 - Other Alzheimer's disease
☐ Diagnostic	☐ G30.9 – Alzheimer's disease, unspecified
☐ Prenatal	☐ F05 - Delirium, if applicable
☐ MCC	☐ F02.80 - Dementia without behavioral disturbance
☐ Exclude VUS	☐ F02.81 - Dementia with behavioral disturbance
☐ Other	☐ F03.90 - Unspecified dementia without behavioral disturbance
Clinical/Suspected Diagnosis: Please attach medical records or complete Page 2	☐ F03.91 - Unspecified dementia with behavioral disturbance
	☐ Z72.89 - Other problems related to lifestyle

8. PATIENT INFORMED CONSENT

1. **PURPOSE:** I understand that my healthcare provider has ordered one or more tests offered by GeneStreet to determine if I have certain genetic disorders.
2. **METHODS:** Testing is performed on isolated DNA from an oral buccal (cheek) swab, or small sample of blood, or a saliva sample. Once collected, the sample will be sent to GeneStreet for testing.
3. **RISKS AND LIMITATIONS:** My healthcare provider has explained the effectiveness and limitations of the test(s), and I understand that the test results may not provide definitive conclusions regarding risk for disease. While this testing is highly accurate, rare testing errors may occur. Accurate results may not be obtained for reasons including but not limited to sample mix-up, bone marrow transplant, recent blood transfusion, or technical problems. Sometimes for technical reasons, results cannot be generated. Additional samples may be needed if results are not generated.
4. **TESTING OF ADDITIONAL FAMILY MEMBERS** may be requested, which could discover previously unknown information about family relationships.
5. **DISCLOSURE OF TEST RESULTS:** GeneStreet's clinical reports are released only to the certified healthcare professional(s) listed on the test requisition form. Clinical reports are confidential and will only be released to other medical professionals with my explicit written consent.
6. **NONDISCRIMINATION:** There are state and federal laws that prohibit discrimination against individuals for the purpose of employment or obtaining health insurance and that prohibit insurers and employers from seeking an individual's genetic information without consent. In accordance with such laws, BioConfirm will not disclose or interpret my genetic information for use by employers or insurers. However, it is my responsibility to consider the possible impact of my test results as they relate to insurance rates, obtaining disability or life insurance, and employment. The Genetic Information Nondiscrimination Act (GINA), a US Federal law, provides some protections against genetic discrimination. For more information on GINA visit www.genome.gov/10002328.
7. **GENETIC COUNSELING:** I understand that GeneStreet recommends that I consult with a genetic counselor before consenting to this test and a genetic counselor or my healthcare provider about my results. For a list of medical geneticists and counselors who may be available in my area, I may visit the National Society of Genetic Counselors website at www.nsgc.org. Genetic Counseling is also available through GeneStreet.
8. **PRIVACY:** I understand that my data and personal information will be stored and protected in compliance with applicable regulatory requirements and I acknowledge that I have read and understand GeneStreet's Privacy Policy and Notice of Privacy Practices.
9. **RECONTACT:** I understand that our knowledge of genetic information will improve over time, and new information may become available in the future that could impact the interpretation of my results, and that GeneStreet may notify me of clinical updates related to my genetic profile (in consultation with my primary clinician as indicated).
10. I understand that my consent to testing is voluntary, and I may choose not to have my sample tested.
11. I authorize GeneStreet to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay GeneStreet for the services rendered. I understand that I may be financially responsible for portions of this test not covered by my insurance.
12. I have a right to receive a copy of this form.
13. ☐ **Optional**: I consent to use of my de-identified test samples for research.
14. ☐ **Optional**: I consent to be contacted by GeneStreet for research opportunities.

Patient Signature _____ **Date** _____

9. CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY
PLEASE COMPLETE MEDICAL NECESSITY FORM ON REVERSE SIDE OF THIS FORM

By signing below, I, the ordering Medical Provider, certify that the patient(s) has been informed of the benefits and limitations of the laboratory test(s) requested, has had the opportunity to have all questions answered adequately, has been offered genetic counseling, and has given their consent for genetic testing. I, the Medical Provider confirm that testing requested is medically necessary and that test results may impact medical management for the patient(s).

Ordering Physician Signature _____ **Date** _____

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10. CLINICAL HISTORY FORM

Patient Name: _____ **Patient DOB:** _____

11. ETHNICITY

☐ African/African American	☐ East Asian	☐ Mediterranean	☐ South East Asian
☐ Ashkenazi Jewish	☐ French Canadian	☐ Native American	☐ More than one ethnicity
☐ Caucasian	☐ Hispanic/Latin American	☐ Sephardic Jewish	☐ Other

12. CLINICAL HISTORY

☐ Mosaicism	☐ Bone Marrow Transplant	☐ Known Chromosomal Gain/Loss
☐ Consanguinity	☐ Organ Transplant	☐ Known Gene Gain/Loss

Please specify any that are checked above:

There are many factors which may affect genetic diagnostic testing: such as gene-gene interactions, high-risk ethnicity groups, and transplants. Please list any that may apply.

13. CLINCIAL PRESENTATION

☐ Behavior	☐ Pedigree/Family History	☐ Physical
☐ Conditions	☐ Phenotypes	☐ Symptoms

There are many presentations which may not seem like a direct association for disease. Please list the most suspected presentations and attach detailed medical records and/or pedigree.

14. CLINCIAL TESTING

☐ Karyotype	☐ Hearing	☐ Imaging
☐ Previous Genetic Testing	☐ Growth Measurements	☐ Pathology Reports
☐ Vision	☐ Biochemical Testing	

Please also include tests that had a negative result. These tests help our clinical staff process the results of your testing.

15. FAMILY HISTORY - PLEASE CHECK HERE IF NO PERSONAL HISTORY ☐

Family Member 1 Name	Relation To Patient	Genetic Sex ☐Male ☐Female ☐Unknown	
Diagnosis and/or Symptoms		Age Of Onset	DOB (MM/DD/YYYY)
Family Member 2 Name	Relation To Patient	Genetic Sex ☐Male ☐Female ☐Unknown	
Diagnosis and/or Symptoms		Age Of Onset	DOB (MM/DD/YYYY)
Family Member 3 Name	Relation To Patient	Genetic Sex ☐Male ☐Female ☐Unknown	
Diagnosis and/or Symptoms		Age Of Onset	DOB (MM/DD/YYYY)

16. FAMILY SAMPLES FOR DUO/TRIO TESTING Complete this section if family samples have been submitted for testing

Last Name	**First Name**	**Last Name**	**First Name**
Date Of Birth (MM/DD/YYYY)	Genetic Sex ☐Male ☐Female ☐Unknown	Date Of Birth (MM/DD/YYYY)	Genetic Sex ☐Male ☐Female ☐Unknown
Sample Draw Date (MM/DD/YYYY)	Sample Type ☐Buccal ☐Blood ☐Other Extracted DNA & DNA Source: (Blood, Buccal, Tissue, Fibroblast)	Sample Draw Date (MM/DD/YYYY)	Sample Type ☐Buccal ☐Blood ☐Other Extracted DNA & DNA Source: (Blood, Buccal, Tissue, Fibroblast)
Relation To Primary Patient	Affected/Unaffected Status	Relation To Primary Patient	Affected/Unaffected Status

I have read the Informed Consent document and I give permission to GeneStreet Laboratories to perform genetic testing as described.
☐ **Optional**: I consent to use of my de-identified test samples for research.
☐ **Optional**: I consent to be contacted by GeneStreet Laboratories for research opportunities.
More information is available at www.GeneStreet.com/policies/privacy-policy.

FAMILY MEMBER SIGNATURE	**DATE (MM/DD/YYYY)**

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FAMILY MEMBER SIGNATURE	**DATE (MM/DD/YYYY)**