UPMC | GENOME CENTER
http://www.upmcgenomecenter.com
Genome_Center@upmc.edu p : 412 623 7155
5560 Centre Ave Pittsburgh | PA 15232
Annerose Berndt, DVM, PhD, HCLD(ABB)
UPMC Genome Center Lab Director

NEXT GENERATION SEQUENCING REQUISITION

PLACE BARCODED PATIENT ID LABEL HERE

ORDERING INSTITUTION INFORMATION

Institution Name | NPI #

Authorized Requester | Phone | Fax

Email

Physician/Pathologist | Phone | Fax

Email

PATIENT SAMPLE INFORMATION

Accession # | Hospital / Medical Record

◯ Male ◯ Female ◯ Unknown | Date of Birth (MM / DD / YYYY)

Biological Sex:

Gender Identity (if different from above):

Date of Collection (MM / DD / YYYY)

◯ Blood in EDTA (Lavender top tube)
◯ Saliva Oragene
◯ iSwab TM
◯ Buccal Swab
◯ Extracted DNA**
◯ Tissue (Source:)

Please ensure all samples follow Center Requirements, see Specimen Handling and Transportation below. For samples marked Other please contact before sending.

** NOTE: Extracted DNA/RNA will only be accepted if the isolation of nucleic acids for clinical testing occurs in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/ot the CMS.

RACE (check all that apply)

◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American
◯ Native Hawaiian or Other Pacific Islander ◯ White

Has Patient had a bone marrow transplant/ transfusion: ◯ Yes ◯ No

Date of last transfusion: / / / (2 weeks must pass before samples can be drawn for testing)

ADDITIONAL REPORT REQUEST

Email | Fax | Contact Role

Email | Fax | Contact Role

Patient Last Name | Patient First Name | MI

Address | Phone

City | State. | Zip | ◯ Yes ◯ No Patient discharged from hospital/facility

PHYSICIAN STATEMENT

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical mangement and treatment decisions. The person listed as the Authorized Requester is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Printed Name | Signature | Date (MM / DD / YYYY)

INSURANCE AND BILLING INFORMATION

REQUIRED ITEMS: 1. Copy of the Front /Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3.Name of Ordering Physician (Above) 4. Insured Signature of Authorization (Above)
◉ DO NOT Complete Test Until Patient has confirmed Out Of Pocket Cost

Name of Insured | Insured Date of Birth | Name of Insured | Insured Date of Birth

Patient's Relationship to Insured | Phone of Insured | Patient's Relationship to Insured | Phone of Insured

Address of Insured | Address of Insured

City | State | Zip | City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone | Secondary Insurance Co. Name | Secondary Insurance Co. Phone

Primary Member Policy # | Primary Member Group # | Secondary Member Policy # | Secondary Member Group #

UPMC | GENOME CENTER
http://www.upmcgenomecenter.com
Genome_Center@upmc.edu p : 412 623 7155
5560 Centre Ave Pittsburgh | PA 15232
Annerose Berndt, DVM, PhD, HCLD(ABB)
UPMC Genome Center Lab Director

NEXT GENERATION SEQUENCING REQUISITION

PLACE BARCODED PATIENT ID LABEL HERE

SELF PAY ◯ Credit Card ◯ Check

Please make checks payable to UPMC Genome Center.

INSTITUTIONAL BILL

Institution Name | Institution Code

Institution Contact Name | Institution Phone | Institution Contact Email

Please note that Medicare does not cover routine screening tests. I signed below hereby authorize UPMC to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as many amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending UPMC any and all payments that I receive directly from my insurance company in payment for this test.

Patient's Printed Name | Patient's Signature | Date (MM / DD / YYYY)

CLINICAL INFORMATION

Please give a brief summary of the patient's clinical presentation and the reason for genetic testing, and ICD-10 code in the box provided below. Please also attach a three generation pedigree.

UPMC | GENOME CENTER
http://www.upmcgenomecenter.com
Genome_Center@upmc.edu p : 412 623 7155
5560 Centre Ave Pittsburgh | PA 15232
Annerose Berndt, DVM, PhD, HCLD(ABB)
UPMC Genome Center Lab Director

NEXT GENERATION SEQUENCING REQUISITION

PLACE BARCODED PATIENT ID LABEL HERE

TEST SELECTION

STEP 1. PLEASE SELECT THE SEQUENCING METHOD FOR THE TESTS/PANELS OFFERED BELOW

☐ ***WHOLE EXOME SEQUENCING (WES) GERMLINE*** ◯ *PROBAND* ◯ *DUO* ◯ *TRIO*

☐ ***WHOLE GENOME SEQUENCING (WGS) GERMLINE*** ◯ *PROBAND* ◯ *DUO* ◯ *TRIO*

**** For Duo/Trio sets, a separate requisition is required for each submitted sample.***

STEP 2. PLEASE SELECT THE TESTS/PANELS

☐ ***RARE-UNDIAGNOSED GENETIC DISEASE (RUGD)***

☐ ***HEREDITARY CANCER PANEL*** *(APC, ATM, AXIN2, BARD1, BAP1, BLM, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, DICER1, EPCAM, GREM1/SCG5, HOXB13, FH,FLCN, MEN1, MLH1, MSH2, MSH6, MRE11A, MUTYH, NBN, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD50, RAD51C, RAD51D,SDHA, SDHB, SDHC, SDHD, SMAD4, SMARCA4,STK11, TP53, TSC1, TSC2, VHL, MET, MITF, POT1, RET, SDHAF2)*

☐ ***BREAST AND GYNECOLOGIC CANCER PANEL (Breast, Ovarian, Uterine)*** *(ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, DICER1, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, SMARCA4, STK11, TP53)*

☐ ***GASTROINTESTINAL CANCER PANEL (Colorectal, Gastric, Pancreatic)*** *(APC, ATM, AXIN2, BMPR1A, BRCA1, BRCA2, CDH1, CDKN2A, CHEK2, EPCAM, GREM1, MEN1, MLH1, MSH2, MSH6, MUTYH, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, SDHA, SDHB, SDHC, SDHD, SMAD4, STK11, TP53, TSC1, TSC2, VHL)*

☐ ***ENDOCRINE CANCER PANEL (Thyroid, Paraganglioma/Pheochromocytoma, Hyperparathyroidism)*** *(APC, CHEK2, DICER, MEN1, NF1, PTEN, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TP53, VHL)*

☐ ***GENITOURINARY CANCER PANEL (Renal/Urinary Tract, Prostate)*** *(ATM, BAP1, BRCA1, BRCA2, CHEK2, DICER1, EPCAM, FH, FLCN, HOXB13, MET, MLH1, MSH2, MSH6, NBN, PMS2, PTEN, SDHB, SDHC, SMARCA4, TP53, TSC1, TSC2, VHL)*

☐ ***SKIN CANCER PANEL (Melanoma, Basal Cell Nevus Syndrome)*** *(BAP1, BRCA2, CDK4, CDKN2A, MITF, POT1, PTCH1, PTEN, TP53)*

☐ ***BRAIN/NERVOUS SYSTEM CANCER PANEL*** *(APC, DICER1, EPCAM, MEN1, MLH1, MSH2, MSH6, NF1, PMS2, PTEN, SMARCA4, TP53, TSC1, TSC2, VHL)*

☐ ***SARCOMA PANEL*** *(APC, BLM, DICER1, EPCAM, FH, MSH2, MSH6, NBN, NF1, PMS2, SDHA, SDHB, SDHC, SDHD, TP53)*

☐ ***HEMATOLOGIC CANCER PANEL (Myelodysplastic Syndrome/Leukemia)*** *(ATM, BLM, BRCA2, BRIP1, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, RAD51C, TP53)*

☐ ***COMPREHENSIVE DYSTONIA PANEL (358 GENES)*** ** Please contact the laboratory for a full list of genes*

UGC ACTIONABLE DISORDERS PANEL

Test Description:

UGC SF V3.0 Actionable Disorders Panel analyzes the 73 genes identified as medically actionable by the American College of Medical Genetics and Genomics (ACMG ; Miller *et al.*, 2021). These genes are medically actionable, with clinical management guidelines established for their associated conditions.

☐ ***YES,*** I want my medically actionable 73 gene analysis reported by UGC.

☐ ***NO,*** I do not want my medically actionable 73 gene analysis reported by UGC.

Patient's Printed Name	Patient's Signature	Date (MM / DD / YYYY)

UPMC | GENOME CENTER
http://www.upmcgenomecenter.com
Genome_Center@upmc.edu p : 412 623 7155
5560 Centre Ave Pittsburgh | PA 15232
Annerose Berndt, DVM, PhD, HCLD(ABB)
UPMC Genome Center Lab Director

NEXT GENERATION SEQUENCING REQUISITION

PLACE BARCODED PATIENT ID LABEL HERE

SPECIMEN HANDLING AND TRANSPORTATION:

Please label all containers with 2 unique identifiers (e.g., patient name, MRN, date of birth, date of collection etc). Use sterile technique and close all containers tightly. Samples should be delivered to the lab on the same day of collection unless otherwise stated below. If sample is collected after business hours or missed transportation pick-up, please keep sample in the refrigerator or at room temp and deliver to the lab as soon as possible on the next business day. Samples from off site should be shipped at room temperature for overnight delivery directly to the lab address listed below. In hot weather, a cool pack may be enclosed. DO NOT FREEZE.

Ship Specimens to: UPMC Genome Center, 5560 Centre Avenue Pittsburgh, PA 15232 Ph: 412 623 7155

Whole Blood	Minimum 2 mL of whole blood in EDTA (purple-top) tube. In case 2 mL can not be obtained, please contact us for instructions. If sample is not immediately shipped, it should be refrigerated at 2-8 ° C. The samples should be received within 24 hours of collection and at ambient temperature. In hot weather a cool pack may be enclosed. Do not freeze whole blood.
DNA	Send the DNA specimen in a screw cap tube-at least 5 µg of genomic DNA at a concentration greater than 20 ng/µl. Ship overnight at room temperature. In hot weather a cool pack may be enclosed. **Note: DNA must have been extracted in a CLIA-certified laboratory.**
Saliva	Follow the instructions included in the kit to collect saliva sample. It can be stored at room temperature until shipped. Ship saliva specimens at ambient temperature within 2 weeks of collection.
Buccal Swab	Follow the instructions included in the kit to collect buccal brushes. It should be refrigerated at 2-8 ° C until shipped. Ship buccal swab specimens at ambient temperature within 2 weeks of collection.