

## MUSCULAR DYSTROPHY MOLECULAR GENETICS REQUISITION

 UI Diagnostic Laboratories  
 Department of Pathology  
 200 Hawkins Drive, 5231 RCP  
 Iowa City, Iowa 52242  
 Toll Free: 866-844-2522  
 Local: 319-384-7212  
 Fax: 319-384-7213

<b>FOR CLIENT USE ONLY:</b> Requisition Date: _____ Completed By: _____ Accn#: _____	<b>FOR UIDL USE ONLY</b> UIDL Path #: _____ UIDL MRN#: _____
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<b>PART A - PATIENT INFORMATION - <i>Required</i></b>		
Patient Name: _____		
Street: _____		
City: _____	St: _____	Zip: _____
Phone: (      ) _____		
Date of Birth: _____	Gender:    Male    Female	

<b>PART B - PROVIDER INFORMATION - <i>Required</i></b>		
Referring Facility: _____		
Street: _____		
City: _____	St: _____	Zip: _____
Phone: (      ) _____		Fax: (      ) _____
Ordering/Contact Physician: _____	NPI: _____	Phone: _____
Genetic Counselor (if known): _____		Phone: _____

<b>PART C - SPECIMEN INFORMATION</b> (Complete the appropriate information below or include in an accompanying letter.)	
<b>SPECIMEN COLLECTION DATE:</b> _____	<b>SPECIMEN COLLECTION TIME:</b> _____
<b>SPECIMEN TYPE:</b> <input type="checkbox"/> EDTA Whole Blood <input type="checkbox"/> DNA <input type="checkbox"/> Other (Specify): _____	
<b>Required ICD-9 codes:</b> 1. _____    2. _____    3. _____    4. _____	
<b>PERTINENT CLINICAL HISTORY AND FINDINGS</b> (please attach pedigree if available):     	

This request to order molecular diagnostic tests from University of Iowa Diagnostic Laboratories (UIDL) certifies to UIDL that the ordering physician has obtained informed consent from the patient as required by applicable state or federal laws for each test ordered and that the ordering physician has authorization from the patient permitting UIDL to report results for each test ordered to the ordering physician. **Genetic Counseling and Information:** By requesting testing, the ordering physician assumes responsibility for providing the patient with all associated guidance and counseling regarding the test results. Alternatively, patients can be referred to qualified counseling services by contacting our client service line at ph. (866)844-2522.

<b>Select Test:</b> Refer to the UIDL <a href="#">TEST DIRECTORY</a> for specimen requirements, CPT Codes	
<input type="checkbox"/> Charcot-Marie-Tooth Disease, Axonal type 2B1, CMT2B1 ( <i>LMNA</i> sequencing)	<input type="checkbox"/> Limb Girdle Muscular Dystrophy type 2A ( <i>CAPN3</i> sequencing)
<input type="checkbox"/> Congenital Muscular Dystrophy type 1C, MDC1C ( <i>FKRP</i> sequencing)	<input type="checkbox"/> Limb Girdle Muscular Dystrophy type 2I ( <i>FKRP</i> sequencing)
<input type="checkbox"/> Emery-Dreifuss Muscular Dystrophy, autosomal dominant, EDMD2 ( <i>LMNA</i> seq)	<input type="checkbox"/> Limb Girdle Muscular Dystrophy type 2K ( <i>POMT1</i> sequencing)
<input type="checkbox"/> Emery-Dreifuss Muscular Dystrophy, autosomal recessive, EDMD3 ( <i>LMNA</i> seq)	<input type="checkbox"/> Limb Girdle Muscular Dystrophy type 2L ( <i>FKTN</i> sequencing)
<input type="checkbox"/> Facioscapulohumeral Dystrophy, <i>FSHD</i>	<input type="checkbox"/> Limb Girdle Muscular Dystrophy type 2N ( <i>POMT2</i> sequencing)
<input type="checkbox"/> Fukuyama Congenital Muscular Dystrophy ( <i>FKTN</i> sequencing)	<input type="checkbox"/> Limb Girdle Muscular Dystrophy type 2M ( <i>POMGnT1</i> sequencing)
<input type="checkbox"/> Fukuyama Congenital Muscular Dystrophy (Japanese Founder Mutation PCR)	<input type="checkbox"/> LMNA-Related Dilated Cardiomyopathy, CMD1A ( <i>LMNA</i> sequencing)
<input type="checkbox"/> Limb Girdle Muscular Dystrophy, autosomal recessive common mutation panel	<input type="checkbox"/> Muscle-Eye-Brain Disease ( <i>POMGnT1</i> sequencing)
<input type="checkbox"/> Limb Girdle Muscular Dystrophy, autosomal recessive panel and FKRP seq	<input type="checkbox"/> Myotonic Dystrophy, type 1 (DM1)
<input type="checkbox"/> Limb Girdle Muscular Dystrophy type 1B, ( <i>LMNA</i> sequencing)	<input type="checkbox"/> Walker Warburg Syndrome ( <i>POMT1</i> , <i>POMT2</i> , <i>FKTN</i> , <i>FKRP</i> and <i>POMGnT1</i> sequencing)

<b>PART D - SEND BILL TO:</b> <b>(Required)</b>	<input type="checkbox"/> Referring Institution Contact Person: _____ Address: _____ City, State, Zip _____ Phone: _____ Fax: _____ E-mail: _____ <input type="checkbox"/> Patient's Insurance (Complete billing information must be provided or referring institution may be billed) <i>(Required information is in red)</i>
Please note that the <b>correct birth date of all policy holders</b> is required information. Please attach the following to the requisition: <b>(1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage.</b> <b>OR</b> <b>(2) a printout with patient demographics and insurance information from your practice management system.</b> <i>Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.</i>	