

MUSCULAR DYSTROPHY MOLECULAR GENETICS REQUISITION

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

FOR UIDL USE ONLY: UIDL Path #: UIDL MRN #: _____		
PART B - PROVIDER INFORMATION - <i>Required</i>		
Referring Facility: _____		
Street: _____		
City: _____	St: _____	Zip: _____
Phone: () _____	Fax: () _____	
Ordering/Contact Physician: _____	NPI: _____	Phone: _____
Genetic Counselor: _____	Phone: _____	

PART C - SPECIMEN INFORMATION (Complete the appropriate information below or include in an accompanying letter.)	
SPECIMEN COLLECTION DATE: _____	SPECIMEN COLLECTION TIME: _____
SPECIMEN TYPE: <input type="checkbox"/> EDTA Whole Blood <input type="checkbox"/> DNA <input type="checkbox"/> Other (Specify): _____	
Required ICD-9 codes: 1. _____ 2. _____ 3. _____ 4. _____	
PERTINENT CLINICAL HISTORY AND FINDINGS (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 client services at ph. (866)844-2522.

SELECT TEST: Refer to the UIDL [TEST DIRECTORY](http://www.healthcare.uiowa.edu/uidl) for specimen requirements and CPT Codes at www.healthcare.uiowa.edu/uidl

<input type="checkbox"/> Charcot-Marie-Tooth Disease, Axonal type 2B1, CMT2B1 (<i>LMNA</i> sequencing)	<input type="checkbox"/> Limb Girdle Muscular Dystrophy type 1B, (<i>LMNA</i> sequencing)
<input type="checkbox"/> Congenital Muscular Dystrophy type 1C, MDC1C (<i>FKRP</i> sequencing)	<input type="checkbox"/> Limb Girdle Muscular Dystrophy type 2A (<i>CAPN3</i> sequencing)
<input type="checkbox"/> Congenital Muscular Dystrophy type 1D, MDC1D (<i>LARGE</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"/> <i>ISPD</i> Gene Sequencing	<input type="checkbox"/> Muscle-Eye-Brain Disease (<i>POMGnT1</i> sequencing)
<input type="checkbox"/> Limb Girdle Muscular Dystrophy, autosomal recessive common mutation panel	<input type="checkbox"/> Myotonic Dystrophy, type 1 (DM1)
<input type="checkbox"/> Limb Girdle Muscular Dystrophy, autosomal recessive panel and <i>FKRP</i> seq	<input type="checkbox"/> Walker Warburg Syndrome (<i>POMT1</i> , <i>POMT2</i> , <i>POMGnT1</i> , <i>FKTN</i> , <i>FKRP</i> , <i>ISPD</i> and <i>LARGE</i> sequencing)

PART D - SEND BILL TO: (Required)	<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)
Please note that the correct birth date of all policy holders is required information. Please attach the following to the requisition: (1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage, OR (2) a printout with patient demographics and insurance information from your practice management system. <small>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.</small>	