PREVENTION GENETICS

PREVENTIONGENETICS USE ONLY

Test information is available on our website:
www.PreventionGenetics.com

All testing must be ordered by a qualified Healthcare Provider

THIS FORM MUST ACCOMPANY ALL SPECIMENS

SPECIAL PROJECT - TEST REQUISITION FORM
SP052 - ALS

PERSON COMPLETING FORM	CONTACT (PHONE OR EMAIL)	DATE OF REQUEST
		____/____/____ MONTH / DAY / YEAR

PATIENT INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH
			____/____/____ MONTH / DAY / YEAR

PATIENT ID	SPECIMEN COLLECTION DATE	SEX
	MONTH ____ / DAY ____ / YEAR ____	☐ Male ☐ Female ☐ Other

HAS PATIENT BEEN TESTED PREVIOUSLY AT PreventionGenetics?	SPECIMEN SOURCE	GEOANCESTRY / ETHNICITY
☐ NO ☐ YES, PG ID# ____	☐ Blood	SPECIFY KARYOTYPE ____

BLOOD TRANSFUSION	BONE MARROW TRANSPLANT	CLINICAL INFORMATION
☐ NO ☐ Within Last 30 Days, Date and Type ____/____/____ MONTH / DAY / YEAR TYPE ____	☐ NO ☐ YES ____/____/____ MONTH / DAY / YEAR	Age of onset of first ALS symptom ____ Site of onset: ☐ Limb ☐ Bulbar ☐ Respiratory

TEST SELECTION

TEST CODE	DESCRIPTION	SPECIAL INSTRUCTIONS
☐ 151	*C9orf72* only	SP052
☐ 151, reflex to 11899 **To be eligible for this option, patient MUST have family history of ALS indicated below.**	*C9orf72*, reflex to ALS Panel (*FUS, SOD1,TARDBP, TBK1, VCP*)	

ADDITIONAL INFORMATION

PROVIDER CONSENT

To be eligible for this program, patient must meet one criteria in both Category A AND Category B.
I attest this patient has the following clinical diagnosis and family history, as indicated:

CATEGORY A		CATEGORY B
☐ **Diagnosis of ALS** **OR** ☐ **Diagnosis of ALS / Frontotemporal Dementia**	**AND**	☐ **Family history of ALS in relative.** If yes, select relative(s). First Degree: ☐ Parent(s) ☐ Sibling(s) ☐ Child(ren) Second Degree: ☐ Grandparent(s) ☐ Grandchild(ren) ☐ Aunt(s) / Uncle(s) ☐ Niece(s) / Nephew(s) **AND / OR** ☐ **Family history of dementia in a relative.** If yes, select relative(s). First Degree: ☐ Parent(s) ☐ Sibling(s) ☐ Child(ren) Second Degree: ☐ Grandparent(s) ☐ Grandchild(ren) ☐ Aunt(s) / Uncle(s) ☐ Niece(s) / Nephew(s)

By signing below, you, the Healthcare Provider, agree that you have obtained informed consent from the patient and that they authorize PreventionGenetics to anonymize and share test data and results to promote research and improve the diagnosis and treatment of genetic diseases. The data and results may be used for research purposes as well as to facilitate and improve the diagnosis of genetic changes and diseases in other patients. For these reasons, PreventionGenetics may anonymize and share test data and results with external physicians, scientists, researchers and pharmaceutical companies. No personal identifying information will be shared.

HEALTHCARE PROVIDER SIGNATURE _____ PRINTED NAME _____ DATE _____

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PROVIDER INFORMATION AND REPORTING

Our preferred method of report transmission is uploading to our secure web portal, myPrevent. Please provide an email address, when possible. If you have additional specific reporting requests, indicate them BELOW.

PROVIDER INFORMATION

NEALS SITE

ADDRESS	CITY	STATE	ZIP

REQUESTING PHYSICIAN (First, Last, Degree)	REQUESTING GENETIC COUNSELOR OR ALLIED PROVIDER (First, Last, Degree)
EMAIL ADDRESS (For report access via myPrevent)	**EMAIL ADDRESS** (For report access via myPrevent)

PHONE NUMBER	NPI#	PHONE NUMBER	NPI#

REFERRAL TO GENETIC COUNSELING / ADDITIONAL REPORTING INSTRUCTIONS

☐ **Refer to Advanced Tele-Genetic Gounseling (AT-GC) for post test genetic counseling. AT-GC will have access to report and Test Requisition Form information (general@at-gc.com) and then will contact patient for scheduling. Provide patient phone number and email address for AT-GC use:**

Patient Phone Number _____ **Patient Email Address**_____

INSTITUTIONAL BILLING

BILLING INSTITUTION	PO NUMBER	SPECIAL PROJECT NUMBER
NEALS		SP052

EMAIL INVOICE VIA SECURE EMAIL
PROVIDE EMAIL ADDRESS

SPECIMEN REQUIREMENTS

PREVENTIONGENETICS PREFERRED SPECIMEN TYPE

PLEASE CONTACT US WITH ADDITIONAL SPECIMEN REQUIREMENT QUESTIONS.

WHOLE BLOOD

Collect 3 ml - 5 ml of whole blood in EDTA (purple top tube) or ACD (yellow top tube), minimum 1 ml for small infants.

SHIPPING & HANDLING INSTRUCTIONS

Label all specimen containers with the patient's name, date of birth and/or ID number. At least two identifiers should be listed on specimen containers. We accept specimen deliveries Monday-Saturday.

BLOOD

DO NOT FREEZE. During hot weather, include a frozen ice pack in the shipping container. Place a paper towel or other thin material between the ice pack and the blood tube. In cold weather include an unfrozen ice pack in the shipping container as insulation. At room temperature, blood specimen is stable for up to 48 hours. If refrigerated, blood specimen is stable for up to one week.

DNA GENOTYPING PANEL

For quality control purposes, the PreventionGenetics DNA Genotyping Panel is performed on all clinical specimens. Genotyping results are not included in test reports.

DNA BANKING

DNA Banking has a reduced price of $98 for patients if clinical testing is also being performed at PreventionGenetics. Visit our website at www.PGDNABank.com for information about the process and forms. For questions related to PGDNABanking, contact our DNA Banking Director at (715) 387-0484, ext. 151, or email: dnabanking@preventiongenetics.com.

CONTACT US

For additional questions or concerns, please contact our Client Service Representatives at (715) 387-0484, ext. 0, or our Genetic Counseling Team at option 2, or email: clinicaldnatesting@preventiongenetics.com.

ADDRESS	TESTING KITS
Diagnostic Lab PreventionGenetics 3800 S. Business Park Ave. Marshfield, WI 54449 USA	Clinical testing kits with prepaid return shipping are available for U.S. Clients. We are able to provide clinical testing kits to International clients without the return postage. To order test kits, submit requests through our electronic order form (see website) or contact our Client Service Representatives at (715) 387-0484, ext. 0. **Comment SP052**

GENETIC RESEARCH IN ALS

The Emory ALS Center is inviting those who have undergone ALS genetic testing to participate in a research study. This research will allow scientists to learn more about the landscape of genetic mutations in ALS. There will be no direct benefit to those who choose to participate, but it is hoped that this study will help scientists learn more about the cause of ALS. If you have undergone genetic testing for ALS and are interested in participating, please call the Emory ALS Center at (404) 778-3807 or email alsresearch@emory.edu.