Washington University Physicians
Washington University School of Medicine in St. Louis

SEQUENCING: Diabetes/ER Stress Disorders

Sample shipping address:

Washington University - Department of Pathology & Immunology
Clinical Support Services Office
425 South Euclid Avenue, Campus Box 8024, St. Louis, MO 63110
Tel: (314) 747-7337| Fax: (314) 747-7336
Email: gps@wustl.edu

Sample drop-off locations:

Children's Hospital
One Children's Place
Central Receiving 2N-25
St. Louis, MO 63110
Tel: (314) 454-4161

Institute of Health (IOH) Core Lab
425 S. Euclid Ave.
Room 4701
St. Louis, MO 63110
Tel: (314) 362-1470

This requisition has two pages, please complete both pages to ensure testing

PHYSICIAN ORDERING TEST (Required - NPI)

Name:		
Institution:		
NPI:	Email:	
Address:		
City:	State:	Zip:
Phone:	Fax:	
Alternative Contact Name:		
Phone:	Email:	
NOTES:		

PATIENT IDENTIFICATION

Patient Status ◯ Inpatient ◯ Outpatient ◯ Office visit

Name Last:	First	MI:
DOB (mm/dd/yyyy):	Gender: ☐ Male ☐ Female	
Medical Record # (if applicable):		
Address:		
City:	State:	Zip:

Ethnicity (select all that apply)

☐ African American ☐ Asian ☐ Caucasian/NW European
☐ E Indian ☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic
☐ Mediterranean ☐ Native Hawaiian/Pacific Islander ☐ Other:

SPECIMEN TYPE

Date Collected (mm/dd/yyyy):	Time:
Collected By:	
Sample Type (Select one)	
Peripheral Blood	
Other:	

Directions

1. Draw 3-5 ml of peripheral blood in lavender top EDTA tube
2. Label tube with patient first/last name, DOB, and collection date/time
3. Place tube in a biohazard bag and form into document sleeve of the biohazard bag, ensuring no patient information is visible
4. Ship specimen overnight in appropriate packaging at room temperature or with cold pack (Monday-Thursday only)

REASON FOR TESTING

Required - failure to include diagnosis may delay testing

Diagnosis:

ICD10 Code(s):

TESTING REQUESTED

Select one - all tests include next generation sequencing of all coding exons of listed genes to detect single nucleotide variants and small insertions and deletions

◯ **Rare and Atypical Diabetes Comprehensive Gene Set** - *All genes from the 4 subsets below will be sequenced and analyzed*

- ◯ **Endoplasmic Reticulum (ER) Stress Gene Set** - *CISD2, EIF2AK3, IER3IP1, INS, WFS1*
- ◯ **Hyperinsulinism Gene Set** - *ABCC8, AKT2, CACNA1D, FOXA2, GCK, GLUD1, HADH, HNF1A, HNF4A, INSR, KCNJ11, KDM6A, KMT2D, PGM1, PMM2, SLC16A1, TRMT10A, UCP2*
- ◯ **Permanent Neonatal Diabetes Mellitus (PNDM) Gene Set** - *ABCC8, CP, EIF2AK3, FOXP3, GATA4, GATA6, GCK, GLIS3, HNF1B, IER3IP1, INS, KCNJ11, LRBA, MNX1, NEUROD1, NEUROG3, NKX2-2, PAX6, PCBD1, PDX1, PLAGL1, PTF1A, RFX6, SLC2A2, SLC19A2, STAT3, TRMT10A, WFS1, ZFP57*
- ◯ **Monogenic Diabetes and MODY Gene Set** - *ABCC8, AGPAT2, AIRE, AKT2, APPL1, BLK, CEL, CISD2, CP, EIF2AK3, FOXP3, GATA4, GATA6, GCK, GLIS3, HFE, HNF1A, HNF1B, HNF4A, IER3IP1, INS, INSR, KCNJ11, KLF11, LRBA, MNX1, NEUROD1, NEUROG3, NKX2-2, PAX4, PAX6, PCBD1, PDX1, PLAGL1, PPARG, PTF1A, RFX6, SLC2A2, SLC19A2, STAT3, TRMT10A, WFS1, ZFP57*

Targeted testing for known familial mutation	Gene:	Mutation:
GPS Accession Number: G -	(or include copy of report if performed by outside lab)	Relationship to patient above:

ADDITIONAL NOTES:

Healthcare Professional Signature to Authorize Testing, Statement of Medical Necessity and Transmission of Results Verification

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

The undersigned Client authorizes the Washington University School of Medicine to send Protected Healthcare Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number above. Client acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.

Signature:	Date:

Below, office use only:

Date/Time Received:	Accession Number:	Technician Initial:

SEQUENCING: Diabetes/ER Stress Disorders

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):

INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact our billing office at 314-362- 5641 or via e-mail at path-billing@email.wustl.edu for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):	
CPT Codes and Units Authorized:		
ATTACH COPY OF INSURANCE CARD (if not available, complete the following)		
Policy Holder's Name:	Insurance Co. Name:	
Last First MI	Insurance Co. Phone:	
Policy Holder's Date of Birth (mm/dd/yyyy):	Plan Name:	
Relationship to patient:	ID#:	Group#:

SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our billing office at 314-362-5641 or via e-mail at path-billing@email.wustl.edu.

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR ACCOUNT

I authorize the disclosure of insurance benefit coverage and payment information to Washington University School of Medicine. I authorize Washington University School of Medicine to furnish any medical information requested on myself, or my covered dependents. I assign and authorize insurance payments to Washington University School of Medicine. I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if Washington University School of Medicine is not a participant with my health plan, and/or my health plan does not fully reimburse medical services due to lack of authorization or medical necessity.

Signature of Patient or Guardian	Printed Name of Patient or Guardian	Date

Reference Laboratories/Institutional billing: complete section below

INSTITUTIONAL BILLING

Institution Name:		
Contact Name:		
Email:		
Billing Address:		
City:	State:	Zip:
Phone:	Fax:	