Biochemical Diagnostic Request Form

Greenwood Diagnostic Labs
106 Gregor Mendel Circle • Greenwood, SC 29646
Toll Free: (800) 473-9411 • Fax: (864) 941-8141
Website: www.ggc.org Highlighted boxes are required

LAB USE ONLY

Patient Information (Please Print):

Last Name First MI		Address	
Race/Ethnicity	Sex ☐ M ☐ F	DOB MM/DD/YYYY	City, State, Zip
Specimen Collection Date MM/DD/YYY	Type of specimen	Numeric Identifier (Medical record # or SSN)	Home telephone

Referring Physician:

Name	Address	
Institution	City, State, Zip	
NPI#	Telephone	Fax
Email Address:	Preferred Method to Receive Results: ☐ Secure Email ☐ Fax ☐ Regular Mail	

Additional report to: ☐ **Genetic Counselor** ☐ **Institution** ☐ **Care Coordinator** ☐ **Other:**

Name		Address	
Telephone	Fax	Email:	City, State, Zip

Additional report to: ☐ **Genetic Counselor** ☐ **Institution** ☐ **Care Coordinator** ☐ **Other:**

Name		Address	
Telephone	Fax	Email:	City, State, Zip

Billing:

☐ **Institutional Billing: Complete section 1 on the separate BILLING FORM (page 2)**

☐ **Insurance: Complete section 2 on the BILLING FORM (page 2). Insurance or Medicaid for out-of-state (non-SC) patients is not accepted.**

☐ **Self-pay: Complete section 3 on the separate BILLING FORM (page 2).**

Indication for Study & Clinical Information:

☐ ICD 10 Code(s): _____

_____

☐ Symptomatic, specific findings: _____

_____

☐ Family History _____

☐ Medications or treatment :_____

_____

Is the patient currently pregnant?

☐ No ☐ Yes If so, provide LMP date: _____ or EDC: _____

Please attach pedigree

Is this patient currently on enzyme replacement therapy?

☐ Yes ☐ No If so, name of therapy: _____

Has this patient had a stem cell transplant:

☐ Yes ☐ No If so, date of transplant: _____

Has this patient had a blood transfusion:

☐ Yes ☐ No If so, date of transfusion: _____

If so, type of transfusion: ☐ PRBC ☐ FFP ☐ Platelets

Previous Testing: _____

_____

Sample and shipping requirements

Dried Blood Spot (D) - Fill at least 3 circles completely with a single layer of blood for each circle. Dry spots 3-4 hours prior to sending. Additional instructions are available at: http://www.ggc.org/images/DSB_Sample_Collection__Requirements.pdf

Serum (S) – Red top tube. Ship whole blood overnight at room temperature OR spin down, remove serum and send serum frozen.

Urine – Send frozen.

Plasma (P) – Sodium heparin (green top) tube. Ship whole blood overnight at room temperature OR spin down, remove plasma and send plasma frozen.

Leukocytes (L) – Blood in sodium heparin (green top) tube, Must arrive within 24 hours of draw. Ship overnight at room temperature.

Fibroblasts (F) – Fresh tissue should be placed in transport media (preferred) or sterile saline and shipped overnight. For cultured tissue, please send two T25 flasks overnight. If cultured tissue is being sent, a control flask is requested in addition to the patient sample.

Whole blood (WB) – Blood in sodium heparin (green top) tube, Must arrive within 24 hours of draw. Ship overnight at room temperature.

For molecular testing of metabolic genes, please complete a Molecular Lab Request Form.
Prenatal molecular studies require prior approval. Please contact the lab for specimen requirements.

LAB USE ONLY Accessioned By: Event Codes: FedEx BeavEx UPS DHL WC Other:

EDTA	Na Hep	Plasma / Serum	Urine	Flasks / Tissue	DBS / DNA	Saliva / Swab Buccal	PAX	ACD
RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F

Greenwood Diagnostic Labs

Diagnostic Laboratory Billing Form

This page is required to process any test requests.

LAB USE ONLY

- **Out of State (non-SC) commercial insurance can only be filed for NGS Panels.**
- **No out of state Medicaid will be accepted for any tests.**
- **The following items are needed in order to bill the patient's insurance directly. We will not be able to file the claim if we are missing information.**
  - ☐ **This form must be completed with ALL requested information.**
  - ☐ **A legible copy of both sides of the insurance card**
  - ☐ **Authorization number, authorization letter, or letter of agreement from insurance company**

Patient Information:

Last Name First MI		Address	
Numeric Identifier (Medical record # or SSN)	DOB MM/DD/YYYY	City, State, Zip	Telephone
ICD10 Code(s)			

Section 1: Institutional Billing

Complete section below with institution information. *New clients must complete an INSTITUTIONAL ACCOUNT REQUEST FORM when submitting the order.* Please contact the GGC Billing Office at 864-941-8117 or billing@ggc.org with any questions about your account.

Institution/Organization	Contact Name:	Email:
Billing Address	City, State, Zip	
Account Number:	Telephone	Fax

Section 2: Insurance Information INSURANCE OR MEDICAID FOR OUT-OF-STATE (NON-SC) PATIENTS IS NOT ACCEPTED

MUST INCLUDE LEGIBLE COPY OF INSURANCE CARD (FRONT & BACK)
All information required to file insurance claims.

Primary

Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender ☐ Male ☐ Female
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone

Secondary

Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender ☐ Male ☐ Female
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone

I authorize Greenwood Genetic Center (GGC) Diagnostic Laboratories to furnish any medical information requested of me, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to GGC Diagnostic Laboratories. I understand I am responsible for any co-pay, deductibles, non-authorized, or non-covered services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if the GGC Diagnostic Laboratories is not a participant with my health plan, or my health plan does not fully reimburse my medical services due to lack of authorization for medical necessity.

Printed Name:_____ Signature:_____ Date (MM/DD/YY):_____

Section 3: Self-pay

We accept check/Visa/MasterCard. All information required to process credit card payments.
Payments will be processed prior to initiation of testing.

Payment Method: ☐ Check ☐ Visa ☐ MasterCard	Credit Card Number:	
Amount: (with discount applied if applicable)	Exp. Date	CVV
Cardholder Name(print as it appears on the card):	Cardholder Signature:	Date
Billing address	City, State, Zip	Telephone

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ANALYTES

Panels

☐ **Biochemical Genetics Profile** – requires plasma &urine
Includes: quantitative plasma amino acids, plasma acylcarnitine profile, plasma total & free carnitine, and qualitative urine organic acids

☐ **Storage Disease Panel** – urine
Includes: MPS analysis (quantitative HS/DS/CS/KS & GAGs) Oligosaccharides analysis, and Sialic Acid, total and free

Individual Analytes

☐ Acylcarnitine profile – plasma
☐ Amino acids – plasma (quantitative)
☐ Amino acids – urine (quantitative)
☐ Amino acids – CSF
☐ C5-DC (glutarylcarnitine) – urine
☐ Carnitine, total and free – plasma
☐ Carnitine, total and free – urine
☐ Creatine – urine (Creatine transporter only)
☐ Creatine/GAA – urine (Creatine biosynthesis disorders)
☐ Creatine/GAA – plasma (Creatine biosynthesis disorders)
☐ Creatine kinase – serum
☐ Galactose-1-phosphate – (red blood cells, sodium heparin tube)
☐ Homocysteine– plasma
☐ MPS urine analysis (quantitative HS/DS/CS/KS & total GAGs)
☐ Oligosaccharides analysis – urine
☐ Organic acids – urine
☐ Orotic acid – urine
☐ Sialic Acid, total and free – urine
☐ Total Glycosaminoglycans (GAGs), quantitative – urine
☐ Tryptophan – plasma

MONITORING TESTS

Mucopolysaccharidoses

☐ MPS I/II (Total GAGs, DS, HS) - urine
☐ MPS III (Total GAGs, HS) – urine
☐ MPS IV (Total GAGs, KS, CS) – urine
☐ MPS VI (Total GAGs, DS) – urine
☐ MPS VII (Total GAGs, DS, CS) – urine

Gaucher Disease

☐ Chitotriosidase – plasma

Pompe Disease

☐ Glucose tetrasaccharide (Glc4) – urine

☐ DNA Banking – requires purple-top (EDTA) tube

☐ Other _____

ENZYMES

Panels

☐ **Dried Blood Spot Lysosomal Panel – 12 enzymes** (D)
Alpha-mannosidosis, Aspartylglucosaminuria, Beta-mannosidosis, Fabry, Fucosidosis, Gaucher, GM1 gangliosidosis, Krabbe, Niemann-Pick A/B, Neuronal Ceroid Lipofuscinosis 2, Pompe, & Schindler

☐ **Dried Blood Spot Mucopolysaccharidosis Panel – 7 enzymes** (D)
MPS I, II, III B, IV A & B, VI and VII

☐ **Hydrops Panel – 4 enzymes** (skin fibroblasts only)
Gaucher, GM1 gangliosidosis, Sialidosis & Sly syndrome

☐ **Lysosomal Panel – 13 enzymes** (WB)
Alpha-mannosidosis, Aspartylglucosaminuria, Beta-mannosidosis, Fabry, Fucosidosis, Gaucher, GM1 gangliosidosis, Hurler, Krabbe, Metachromatic Leukodystrophy, Niemann-Pick A/B, Schindler, & Tay-Sachs/Sandhoff

☐ **Morquio Syndrome Panel – 2 enzymes** (L, F, D)
MPS IV A & B

☐ **Mucolipidosis II/III Dried Blood Spot Screen – 4 enzymes** (D)
Acid sphingomyelinase, Alpha-iduronidase, Alpha-mannosidase, & Beta-glucosidase

☐ **Mucolipidosis II/III Plasma Screen – 3 enzymes** (WB, P)
Alpha-fucosidase, Beta-glucuronidase, Hexosaminidase

☐ **Mucopolysaccharidosis (MPS) Panel – 10 enzymes** (WB, F)
MPS I, II, III A-D, IV A & B, VI and VII *requires 2 green tops

☐ **Multiple Sulfatase Deficiency Panel – 3 enzymes** (WB, D, F)
Arylsulfatase B, Iduronate-2-sulfatase, & N-acetyl-galactosamine-6-sulfatase

☐ **Oligosaccharidoses Panel – 6 or 7 enzymes** (L, D, F)
Alpha-mannosidosis, Aspartylglucosaminuria, Beta-mannosidosis, Fucosidosis,GM1 gangliosidosis, & Schindler (Sialidase only if fibroblasts are submitted)

☐ **Neurological Panel – 9 enzymes** (WB)
Fabry, Gaucher, GM1 gangliosidosis, Krabbe, Metachromatic Leukodystrophy, Neuronal Ceroid Lipofuscinosis 1, Neuronal Ceroid Lipofuscinosis 2, Niemann-Pick A/B, & Tay-Sachs/Sandhoff

☐ **Sanfilippo Syndrome Panel – 4 enzymes** (WB, F)
MPS III A-D

Individual Enzymes

☐ Alpha-mannosidosis (α-mannosidase)	L,F,D
☐ Aspartylglucosaminuria (aspartylglucosaminidase)	P,L,D
☐ Beta-mannosidosis (β-mannosidase)	L,F,D
☐ Biotinidase deficiency (biotinidase)	P,S
☐ Fabry disease (α-galactosidase)	L,F,D
☐ Fucosidosis (α-fucosidase)	L,F,D
☐ Gaucher disease (β-glucosidase)	L,F,D
☐ GM1 gangliosidosis (β-galactosidase)	L,F,D
☐ Hunter syndrome, MPS II (Iduronate-2-sulfatase)	P,F,D
☐ Hurler syndrome, MPS I (α-iduronidase)	P,L,F,D
☐ Krabbe Disease (galactocerebrosidase)	D
☐ Maroteaux Lamy syndrome, MPS VI (arylsulfatase B)	L,F,D
☐ Metachromatic leukodystrophy (arylsulfatase A)	L,F
☐ Morquio, type A (N-acetyl-galactosamine-6-sulfatase)	L,F,D
☐ Morquio, type B (β-galactosidase)	L,F,D
☐ Neuronal Ceroid Lipofuscinosis 1 (palmitoyl-protein thioesterase 1)	L
☐ Neuronal Ceroid Lipofuscinosis 2 (tripeptidyl peptidase 1)	L,D
☐ Niemann-Pick A/B (acid sphingomyelinase)	D
☐ Pompe disease (α-1,4-glucosidase)	L,F,D
☐ Sanfilippo A (heparan-N- sulfatase)	L,F
☐ Sanfilippo B (N-acetyl-α-glucosaminidase)	P,F,D
☐ Sanfilippo C (acetyl CoA:glucosamine N-acetyltransferase)	L,F
☐ Sanfilippo D (N-acetyl glucosamine-6-sulfatase)	L,F
☐ Schindler/Kanzaki Disease (N-acetyl-alpha galactosaminidase)	P,L,F,D
☐ Sialidosis (α-neuraminidase, sialidase)	F
☐ Sly syndrome, MPS VII (β-glucuronidase)	L,F,D
☐ Tay-Sachs/Sandhoff disease (β-hexosaminidase) *no carrier testing	L,P