**MOLECULAR GENETICS FORM**  
**FOR DNA ANALYSIS**

<table>
<thead>
<tr>
<th>Patient Name (please print):</th>
<th>Gender</th>
<th>Patient's Mother's First Name</th>
<th>Medical Record Number (MRN):</th>
<th>Hospital:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
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</tbody>
</table>

**Statement of Financial Responsibility**

I authorize any holder of medical or other information about me to release to my healthcare provider, third party processor, and the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this healthcare encounter or related claim. I permit a copy of this authorization to be used in place of the original and request payment of authorized insurance benefits be made on my behalf to the WFU Physicians. I understand I am responsible for payment of these charges. I am also responsible for payment if my insurance carrier decides this is a non-covered service or requires prior authorization, which I did not obtain.

**Ordering Physician**

<table>
<thead>
<tr>
<th>Ordering Physician (Last, First):</th>
<th>Phone/Pager:</th>
<th>Fax:</th>
</tr>
</thead>
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<tr>
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</table>

**Billing Information**

<table>
<thead>
<tr>
<th>Bill:</th>
<th>Insurance Company:</th>
<th>Relationship to Patient:</th>
<th>Policy ID/Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forsyth Novant</td>
<td>Medicaid</td>
<td>Patient</td>
<td>Carolina Access #:</td>
</tr>
<tr>
<td>Moses Cone Clinical Lab</td>
<td>Women’s Hosp Greensboro Clinical Lab</td>
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</tbody>
</table>

**Specimen Collection Requirements:**

5 to 10cc of blood collected in a purple top EDTA tube – room temperature.

**Type of Specimen:**

- Blood
- Bone Marrow
- Amniotic Fluid
- Tissue
- Check Swab
- Paraffin Block

**DNA (must be extracted in a CLIA-accredited lab)**

**Collect Date:**

<table>
<thead>
<tr>
<th>Collect Date:</th>
<th>Collect Time:</th>
<th>Collected by:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Signs/Symptoms/Indication (ICD-10 codes) for a DNA Study**

Check all that apply. Codes here do not represent entire listing of ICD-10 codes available; please consult current ICD-10 coding manual for complete listing.

- ADHD (F90.2)
- AML (C92.00)
- AML in remission (C92.01)
- AML in relapse (C92.02)
- Autism – infantile (F84.0)
- Cystic Fibrosis screening (Z13.228)
- Additional Clinical Information/ICD-10 codes (specify): 

**Test(s) Requested**

Note: When ordering tests for which Medicare reimbursement is sought, it is recommended that the Provider consult any Local Medical Review Policies (LMRP) or National Coverage Decisions (NCD) that may be applicable to the test(s) being ordered. Based on guidance issued in either of these policies, it may be necessary to obtain an Advanced Beneficiary Notice (ABN) from the Medicare Patient. For Medicaid and other carriers, a signed Statement of Financial Responsibility from the patient may be necessary (see above).

- Angelman/Prader-Willi (PW) Syndrome (SNRPN Methylation)
- Cystic Fibrosis Genotype (CFTR) (specify ethnic background below)
- Cystic Fibrosis Carrier Screen (specify ethnic background below)
- Fragile X-associated Tremor/Ataxia Syndrome (FMR1)
- Fragile X Syndrome (FMR1)
- Spinal Muscular Atrophy Screen (SMN1)
- Spinal Muscular Atrophy Diagnostic (SMN1/2)

**Ethnic Background (Important for accurate Cystic Fibrosis test interpretation)**

- NW European Caucasian
- Mixed European Caucasian
- Other Jewish
- Hispanic
- Native American
- SE European Caucasian
- Ashkenazi Jewish
- Asian
- African American
- Other (specify): 

**Revised 8/22**