Athena Diagnostics Nephrology Client Test Requisition (April 2017)

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

NOTE: Client services is now available until 9:00 PM ET. They can be reached at 800-394-4493, option 2.

athena diagnostics

Fields in red indicate required information

Complete this requisition for direct billing to hospitals, laboratories or clinics.

If you wish to have Athena Diagnostics bill the insurance company directly, please use the Insurance Test Requisition.

Please note: Athena Diagnostics must bill hospitals directly for all Medicare hospital inpatient and outpatient testing.

Who Should Athena Diagnostics Contact with Questions About this Order?

Name _____

Phone _____

Fax _____

Email _____

Tests Ordered

Important: Write in the test code and test name (see list on reverse).

Code _____ Name _____

Code _____ Name _____

ICD Code (Required): _____

Hospital/Laboratory Billing Information

(Hospital billing is required for all Medicare patients – both inpatients and outpatients.)

Athena Account # (if assigned) _____

CLIA # _____

Purchase Order # (if available) _____

Billing Contact _____

Email _____

Phone _____

Fax _____

Hospital/Lab Name _____

Address _____

City _____

State _____ Zip _____

Patient Identification

NOTE: Two forms of patient ID must be listed on EACH specimen tube.

Patient Name _____ (First / Last)

Patient ID # (if available) _____

Last Four Digits of SS# _____ Sex: ☐ Male ☐ Female ☐ Unknown

DOB _____

Age _____

Mailing Address _____

_____

City _____ State _____ Zip _____

Phone #1 _____ ☐ Day ☐ Eve ☐ Cell

Phone #2 _____ ☐ Day ☐ Eve ☐ Cell

Authorization to Use De-identified Specimen for Research. To promote medical understanding and develop better health insights, Athena Diagnostics requests your permission to use your specimen in a de-identified way (without identifying information) for research, educational studies, commercial purposes and/or publication, if appropriate. Your name or other personal identifying information will not be used in or linked to the results of any studies and publications. Your refusal to have your specimen used or not used for research purposes will not affect processing or testing of your specimen, your test results or the service support provided by Athena Diagnostics to your physician. Please indicate your approval by checking the box next to **Yes** or denial by checking the box next to **No**.

I consent to the use of my de-identified specimen for research: ☐ **Yes** ☐ **No**

_____

Signature of Patient, Parent or Legally Authorized Representative Date

_____

Printed Name of Patient, Parent or Legally Authorized Representative Date

_____

Relationship to Patient if Signatory is Someone Other than Patient

Authorized Result Report Recipients Required Physician Information

NPI # _____ UPIN # _____

Name _____ (First / Last)

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Laboratory Information

CLIA # _____

Lab Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Indications for Testing (Check One)

☐ Diagnostic (symptomatic) ☐ Predictive (asymptomatic) ☐ Prenatal ☐ Carrier ☐ Family Testing

Physician Attestation of Informed Consent

In accordance with Massachusetts General Law Chapter 111, Section 70G, and New York Civil Rights Law Section 79-1 verification of patient informed consent is required for genetic testing. Additionally, testing laboratories located in Massachusetts require a signed acknowledgement from the ordering medical practitioner. The signed acknowledgement is required to complete the genetic testing ordered if you have not previously signed a blanket Physician Attestation of Informed Consent (PAIC) at any Quest lab. The company offers a blanket PAIC that can be signed for all future orders.

I warrant that I have obtained both oral and written consent using the **Patient Informed Consent Form for Genetic Testing** provided by Athena Diagnostics. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person).

_____ _____

Medical Practitioner Signature Date Printed Name of Medical Practitioner NPI

Patient Informed Consent Form for Genetic Testing is available at AthenaDiagnostics.com/consent.

Type of Specimen ☐ Whole Blood ☐ CVS: Cultured ☐ Amniotic Fluid: Cultured Date Collected _____

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, last four digits of SS#, patient ID no. These same two forms of ID must also be indicated on the test requisition.

Note: Test requisitions become outdated. For the most accurate and up-to-date test offering, please visit AthenaDiagnostics.com. Reflex testing will be performed at an additional charge.

Athena Diagnostics, Inc., 200 Forest Street, 2nd Floor, Marlborough, MA 01752 • 800-394-4493 • Fax 610-271-6085 • AthenaDiagnostics.com

Nephrology Client Test Requisition (April 2017)

Important: Please be sure to write in test code and test name in the Tests Ordered section on front.

Test Code		Pref. Spec.	Pref. Vol.	Tube Type
Alport Syndrome				
☐ **759**	**Complete Alport Syndrome Evaluation** (COL4A3,4,5 DNA Sequencing; COL4A5 Deletion Test)	B	8 mL	L
☐ 755	COL4A5 Sequencing and Deletion Analysis	B	8 mL	L
☐ 756	COL4A5 Deletion Analysis	B	8 mL	L
☐ 757	COL4A3 DNA Sequencing Test	B	8 mL	L
☐ 758	COL4A4 DNA Sequencing Test	B	8 mL	L
Amyloidosis				
☐ 235	TTR DNA Sequencing Test	B	8 mL	L
Bardet-Biedl Syndrome				
☐ **887**	**Bardet-Biedl Syndrome Evaluation** (BBS1, BBS2, BBS10)	B	8 mL	L
☐ 871	BBS1 (BBS) DNA Sequencing Test	B	8 mL	L
☐ 872	BBS2 (BBS) DNA Sequencing Test	B	8 mL	L
☐ 886	BBS10 (BBS) DNA Sequencing Test	B	8 mL	L
Fanconi Syndrome				
☐ 517	MELAS mtDNA Evaluation (MELAS 3243, 3271, 3252, 3256, 3291, 13513)	B	8 mL	L
Family Testing				
☐ **185**	**Familial DNA Sequence Evaluation** This test detects previously identified sequence variants in at-risk family members. Proband Accession # _____ Relationship _____	B	8 mL	L
Hereditary Renal Tubular Disorders				
☐ **767**	**Hereditary Renal Tubular Disorders Evaluation** (SLC12A1, KCNJ1, CLCNKB, BSND, SLC12A3)	B	8 mL	L
☐ 762	SLC12A1 DNA Sequencing Test	B	8 mL	L
☐ 763	KCNJ1 DNA Sequencing Test	B	8 mL	L
☐ 764	CLCNKB DNA Sequencing Test	B	8 mL	L
☐ 765	BSND DNA Sequencing Test	B	8 mL	L
☐ 766	SLC12A3 DNA Sequencing Test	B	8 mL	L
☐ 825	CASR DNA Sequencing Test	B	8 mL	L
Monogenic Hypertension				
☐ **749**	**Monogenic Hypertension Evaluation** (SCNN1B, SCNN1G, CYP11B1, HSD11B2)	B	8 mL	L
☐ 747	Liddle's Syndrome Evaluation (SCNN1B, SCNN1G)	B	8 mL	L
☐ 748	Pseudohypoaldosteronism Type 1 Evaluation (SCNN1A, SCNN1B, SCNN1G)	B	8 mL	L
☐ 772	SCNN1A DNA Sequencing Test	B	8 mL	L
☐ 745	SCNN1B DNA Sequencing Test	B	8 mL	L
☐ 746	SCNN1G DNA Sequencing Test	B	8 mL	L
☐ 774	CYP11B1 DNA Sequencing. Test	B	8 mL	L
☐ 775	HSD11B2 DNA Sequencing Test	B	8 mL	L
☐ 779	CYP11B1/CYP11B2 Chimeric Gene Fusion Test	B	8 mL	L
Nephrogenic Diabetes Insipidus				
☐ **854**	**Nephrogenic Diabetes Insipidus Evaluation** (AVPR2, AQP2)	B	8 mL	L
☐ 851	AVPR2 DNA Sequencing Test	B	8 mL	L
☐ 852	AQP2 DNA Sequencing Test	B	8 mL	L
Nephronophthisis				
☐ 750	NPHP1 Deletion Test (Familial Juvenile Nephronophthisis)	B	8 mL	L

Test Code		Pref. Spec.	Pref. Vol.	Tube Type
Nephrotic Syndrome				
☐ **722**	**Early Onset Nephrotic Syndrome Evaluation** (PLCE1, LAMB2, WT1, NPHS1, NPHS2)	B	8 mL	L
☐ **717**	**Focal and Segmental Glomerulosclerosis (FSGS) Evaluation** (INF2, ACTN4, TRPC6, NPHS2)	B	8 mL	L
☐ 711	ACTN4 DNA Sequencing Test	B	8 mL	L
☐ 712	TRPC6 DNA Sequencing Test	B	8 mL	L
☐ 716	INF2 DNA Sequencing Test	B	8 mL	L
☐ 718	PLCE1 DNA Sequencing Test	B	8 mL	L
☐ 713	WT1 DNA Sequencing Test	B	8 mL	L
☐ 714	LAMB2 DNA Sequencing Test	B	8 mL	L
☐ 710	NPHS2 DNA Sequencing Test	B	8 mL	L
☐ 730	NPHS1 DNA Sequencing Test	B	8 mL	L
Polycystic Kidney Disease				
☐ 728	PKDx® Familial Mutation Evaluation (PKD1 and PKD2 Single Exon Sequencing) Proband Accession # _____ Relationship _____	B	8 mL	L
☐ 8100	Complete PKDx Evaluation	B	8 mL	L
☐ 8105	PKD1 Deletion Test	B	8 mL	L
☐ 8101	PKD1 DNA Sequencing and Deletion Evaluation	B	8 mL	L
☐ 8103	PKD1 DNA Sequencing Test	B	8 mL	L
☐ 8106	PKD2 Deletion Test	B	8 mL	L
☐ 8102	PKD2 DNA Sequencing and Deletion Evaluation	B	8 mL	L
☐ 8104	PKD2 DNA Sequencing Test	B	8 mL	L
Other Cystic Diseases				
☐ **556**	**Complete Tuberous Sclerosis Evaluation** (TSC1 Sequencing, TSC1 Deletion, TSC2 Sequencing, TSC2 Deletion)	B	8 mL	L
☐ 521	TSC1 DNA Sequencing Test	B	8 mL	L
☐ 508	TSC1 Deletion Test	B	8 mL	L
☐ 522	TSC2 DNA Sequencing Test	B	8 mL	L
☐ 523	TSC Familial Mutation Evaluation Proband Accession # _____ Relationship _____	B	8 mL	L
☐ 524	TSC2 DNA Deletion Test	B	8 mL	L
☐ 770	Hereditary Interstitial Kidney Disease (UMOD) DNA Sequencing Test	B	8 mL	L
☐ 836	TCF2 DNA Sequencing Test (Renal Cysts and Diabetes Syndrome (RCAD))	B	8 mL	L
Renal Cancer				
☐ **889**	**Pheochromocytoma Evaluation** (RET, VHL, SDHB)	B	8 mL	L
☐ 813	MEN2 (RET) DNA Sequencing Test	B	8 mL	L
☐ 818	MEN1 (MEN1) DNA Sequencing Test	B	8 mL	L
☐ 888	SDHB DNA Sequencing Test	B	8 mL	L
☐ 858	von Hippel-Lindau Syndrome (VHL) DNA Sequencing Test	B	8 mL	L
Renal Cysts and Diabetes				
☐ 776	HNF1ß DNA Sequencing and Deletion Evaluation (RCAD)	B	8 mL	L
Rickets				
☐ **857**	**Hypophosphatemic Rickets Evaluation** (PHEX, FGF23)	B	8 mL	L
☐ 855	PHEX (Hypophosphatemic Rickets) DNA Sequencing Test	B	8 mL	L
☐ 856	FGF23 (Hypophosphatemic Rickets) DNA Sequencing Test	B	8 mL	L

Specimen Requirements: 8 mL (6 mL minimum) whole blood collected in an EDTA (lavender-top) tube.

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, last four digits of SS#, patient ID no. These same two forms of ID must also be indicated on the test requisition.

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