Athena Diagnostics
International Nephrology Test Requisition (April 2015)

athena diagnostics

Complete this requisition for all international samples. Athena requires that international specimens be accompanied by payment in U.S. dollars. If pre-payment is not received, there will be a delay in result reporting.

Please call our Client Services Department at 00-1-508-756-2886, option 2 or contact us on our website at AthenaDiagnostics.com/international if you have questions regarding shipping or if you need further information.

Who Should Athena Contact with Questions About this Order?

Name_____
First Last

Phone_____ Fax_____

Email _____

Tests Ordered*

Check the test(s) required on the reverse **or** write in below.

Test Code_____ Test Name_____

Test Code_____ Test Name_____

Payment Information

☐ Bank Check Enclosed (made payable to Athena Diagnostcs, Inc.)

☐ Credit Card:

☐ Visa ☐ Discover ☐ MC ☐ AMEX

Credit Card #_____

Exp:_____Security Code:_____

Cardholder Name:_____
As it appears on card

Billing Address:

_____

_____

_____

☐ Wire Transfer (Athena will send you wire transfer details.)

Fax Number:_____

E-Mail:_____

Testing will not begin until payment is received.

Laboratory Information

Lab Name_____

Complete Lab Address:

_____

_____

_____

_____

_____

Phone_____ Fax_____

***Indicates required information**

Patient Identification

Patient Name*_____
First Last

DOB*_____ Sex: ☐ Male ☐ Female ☐ Unknown

Age*_____

Patient ID # (if available)_____

Authorization to Use De-Identified Sample or Data 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 or data 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

Name_____
First Last

Complete Mailing Address:

_____

_____

_____

_____

_____

Indications for Testing (Check One)

☐ Diagnostic (symptomatic) ☐ Clinical Study ☐ Prenatal

☐ Predictive (asymptomatic) ☐ Carrier ☐ Other Research

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

Date Collected*_____

☐ Whole Blood ☐ Serum ☐ CSF ☐ Muscle ☐ Plasma ☐ DNA: Volume_____ Concentration_____

Once this form is complete, please ensure that you have:

☐ **Verified the specimen type and included date of collection**

☐ **Verified that the Indications for Testing section has been completed by the physician**

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

200 Forest Street, 2nd Floor, Marlborough, MA 01752 • 00-1-508-756-2886 • Fax 00-1-610-271-6085 • AthenaDiagnostics.com

Nephrology Patient Insurance Test Requisition (April 2015)

Test Code		Pref. Spec.	Min. Vol.	Tube Type
Alport Syndrome				
☐	**759 Complete Alport Evaluation** (COL4A3,4,5 DNA Sequencing; COL4A5 Deletion Test)	B	20 mL	L
☐	755 COL4A5 DNA Sequencing and Deletion Test	B	20 mL	L
☐	756 COL4A5 Deletion Test	B	20 mL	L
☐	757 COL4A3 DNA Sequencing Test	B	20 mL	L
☐	758 COL4A4 DNA Sequencing Test	B	20 mL	L
Amyloidosis				
☐	235 Amyloidosis Evaluation (TTR)	B	20 mL	L
Bardet-Biedl Syndrome				
☐	**887 Bardet-Biedl Syndrome Evaluation** (BBS1, BBS2, BBS10)	B	10 mL	L
☐	871 BBS1 (BBS) DNA Sequencing Test	B	10 mL	L
☐	872 BBS2 (BBS) DNA Sequencing Test	B	10 mL	L
☐	886 BBS10 (BBS) DNA Sequencing Test	B	10 mL	L
Fanconi Syndrome				
☐	517 MELAS mtDNA Evaluation (MELAS 3243, 3271, 3252, 3256, 3291, 13513)	B	20 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	10 mL	L
Hereditary Renal Tubular Disorders				
☐	**767 Hereditary Renal Tubular Disorders Evaluation** (SLC12A1, KCNJ1, CLCNKB, BSND, SLC12A3)	B	10 mL	L
☐	762 SLC12A1 DNA Sequencing Test (Bartter type 1)	B	10 mL	L
☐	763 KCNJ1 DNA Sequencing Test (Bartter type 2)	B	10 mL	L
☐	764 CLCNKB DNA Sequencing Test (Bartter type 3)	B	10 mL	L
☐	765 BSND DNA Sequencing Test (Bartter type 4)	B	10 mL	L
☐	766 SLC12A3 DNA Sequencing Test (Gitelman)	B	10 mL	L
☐	825 Autosomal Dominant Hypocalcemia (CASR) Evaluation	B	10 mL	L
Monogenic Hypertension				
☐	**749 Monogenic Hypertension Evaluation** (SCNN1B, SCNN1G, CYP11B1, HSD11B2)	B	10 mL	L
☐	**747 Liddle's Syndrome Evaluation** (SCNN1B, SCNN1G)	B	10 mL	L
☐	**748 Pseudohypoaldosteronism Type 1 Evaluation** (SCNN1A, SCNN1B, SCNN1G)	B	10 mL	L
☐	772 SCNN1A DNA Sequencing Test	B	10 mL	L
☐	745 SCNN1B DNA Sequencing Test	B	10 mL	L
☐	746 SCNN1G DNA Sequencing Test	B	10 mL	L
☐	774 CYP11B1 DNA Sequencing. Test	B	10 mL	L
☐	775 HSD11B2 DNA Sequencing Test	B	10 mL	L
☐	779 CYP11B1/CYP11B2 Chimeric Gene Fusion Test	B	10 mL	L
Nephrogenic Diabetes Insipidus				
☐	**854 Nephrogenic Diabetes Insipidus Evaluation** (AVPR2, AQP2)	B	10 mL	L
☐	851 AVPR2 DNA Sequencing Test	B	10 mL	L
☐	852 AQP2 DNA Sequencing Test	B	10 mL	L
Nephronophthisis				
☐	750 NPH1 (Familial Juvenile Nephronophthisis (FJN)) Molecular Test	B	10 mL	L

Test Code		Pref. Spec.	Min. Vol.	Tube Type
Nephrotic Syndrome				
☐	**722 Early Onset Nephrotic Syndrome Evaluation** (PLCE1, LAMB2, WT1, NPHS1, NPHS2)	B	10 mL	L
☐	**717 Inherited Focal and Segmental Glomerulosclerosis (FSGS) Evaluation** (INF2, ACTN4, TRPC6, NPHS2)	B	10 mL	L
☐	711 ACTN4 DNA Sequencing Test	B	10 mL	L
☐	712 TRPC6 DNA Sequencing Test	B	10 mL	L
☐	716 INF2 DNA Sequencing Test	B	10 mL	L
☐	718 PLCE1 DNA Sequencing Test	B	10 mL	L
☐	713 WT1 DNA Sequencing Test	B	10 mL	L
☐	714 LAMB2 DNA Sequencing Test	B	10 mL	L
☐	710 NPHS2 DNA Sequencing Test (Steroid Resistant Nephrotic Syndrome; Podocin)	B	10 mL	L
☐	730 NPHS1 DNA Sequencing Test (Congenital Nephrotic Syndrome; Nephrin)	B	10 mL	L
Polycystic Kidney Disease				
☐	**761 Complete PKD Evaluation** Step 1. PKD1/PKD2 Sequencing; Step 2. PKD1/PKD2 MLPA			
☐	725 PKDx® DNA Sequencing Test (PKD1 and PKD2 Sequencing)	B	10 mL	L
☐	728 PKDx® Familial Mutation Evaluation (PKD1 and PKD2 Single Exon Sequencing) Proband Accession # _____ Relationship _____	B	10 mL	L
☐	760 PKD Deletion Test (PKD1/PKD2 MLPA)	B	10 mL	L
Other Cystic Diseases				
☐	**556 Complete Tuberous Sclerosis Evaluation** (TSC1 Sequencing, TSC1 Deletion, TSC2 Sequencing, TSC2 Deletion)	B	20 mL	L
☐	521 TSC1 DNA Sequencing Test	B	20 mL	L
☐	508 TSC1 DNA Deletion Test	B	20 mL	L
☐	522 TSC2 DNA Sequencing Test	B	20 mL	L
☐	523 TSC Familial Mutation Evaluation (TSC1 and TSC2 Single Exon Sequencing) Proband Accession # _____ Relationship _____	B	10 mL	L
☐	524 TSC2 DNA Deletion Test	B	10 mL	L
☐	770 Hereditary Interstitial Kidney Disease (2 exon UMOD seq.)	B	10 mL	L
☐	836 TCF2 DNA Sequencing Test (Renal Cysts and Diabetes Syndrome (RCAD))	B	10 mL	L
Renal Cancer				
☐	**889 Pheochromocytoma Evaluation** (RET, VHL, SDHB)	B	10 mL	L
☐	813 MEN2 (RET) Evaluation	B	10 mL	L
☐	818 MEN1 (MEN1) Evaluation	B	10 mL	L
☐	888 SDHB DNA Sequencing Test	B	10 mL	L
☐	858 von Hippel-Lindau Syndrome (VHL) Evaluation	B	10 mL	L
Renal Cysts and Diabetes				
☐	776 HNF1ß DNA Sequencing and Deletion Evaluation (RCAD)	B	10 mL	L
Rickets				
☐	**857 Hypophosphatemic Rickets Evaluation** (PHEX, FGF23)	B	10 mL	L
☐	855 PHEX DNA Seq. Test (X-linked Hypophosphatemic Rickets)	B	10 mL	L
☐	856 FGF23 DNA Sequencing Test (Autosomal Dominant Hypophosphatemic Rickets)	B	10 mL	L

Specimen Requirements & Shipping Information

Specimen Type: B – Blood

Tube Type: L – Lavender

Pediatric Minimum Volume: 2 mL (for blood tests)

Stability: Hemolysis may compromise DNA recovery and integrity after 48 hrs. It is recommended to ship samples immediately after draw. Samples can be stored for short periods only. Send specimen overnight at room temperature.

Shipping: Send specimen overnight at room temperature. If you have any questions on sample requirements or shipping, contact our client service department at 800-394-4493, extension 2.

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.

Athena Diagnostics Client Service Representatives are available from 8:30am to 6:30pm Eastern Time (U.S.).

International Customers please call

00-1-508-756-2886

or Fax 00-1-610-271-6085

athena diagnostics®

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