Courtagen
DIAGNOSTICS LABORATORY

SIGN AND SEND ALL DOCUMENTS TO OUR SECURE FAX – 617-892-7192
Physicians, email genomics@courtagen.com to setup your secure portal for test orders and results

Select tests to order

Mitochondrial Test Panels
- ❑ mtSEEK (37 mito. DNA genes)
- ❑ nucSEEK Comprehensive (~1,200 genes)
- ❑ nucSEEK Focus (181 genes)
- ❑ Additional SNP Analysis
  includes 24 SNPs on report for nucSEEK Comprehensive or nucSEEK Focus tests

Neurodevelopmental Test Panels
- ❑ devSEEK Triome (1,100+ genes)
  requires patient & both parent samples
- ❑ devSEEK (237 genes)
- ❑ devACT (267 genes)
- ❑ Additional SNP Analysis
  includes 60 SNPs on report/1,100+ in file for Combined Neurodevelopmental Analysis, devSEEK Triome, devSEEK, or devACT tests

Seizure Test Panels
- ❑ epiSEEK Triome (~1,100 genes)
  requires patient & both parent samples
- ❑ epiSEEK Comprehensive (471 genes)
- ❑ epiSEEK Focus (76 genes)
- ❑ Additional rxSEEK Epilepsy Report
  drug metabolism report for any epiSEEK test

Combined Test Panels
- ❑ Complete Neurological Analysis
  includes mtSEEK, nucSEEK Comprehensive, devACT, devSEEK, epiSEEK Comprehensive
- ❑ Combined Neurodev. Analysis
  includes devACT & devSEEK
- ❑ Complete Mitochondrial Analysis
  includes mtSEEK & nucSEEK Comprehensive

Other
- ❑ lysoSEEK (95 genes)
- ❑ theraSEEK (299 genes)
  includes 60 SNPs on report/1,100+ in file
- ❑ Targeted Parental Testing
  insurance not accepted

Spotlight Panels

epiSEEK Spotlight Panels
- ❑ Absence Seizures
- ❑ Aicardi-Goutieres Syndrome
- ❑ Benign Epilepsies
- ❑ Brain Malformation Seizures
- ❑ EIEE
- ❑ Fever Sensitive Seizures
- ❑ Focal Seizures
- ❑ Infantile Spasms
- ❑ Joubert Syndrome
- ❑ Myoclonic A (Progressive)
- ❑ Myoclonic B
- ❑ Neonatal Seizures
- ❑ Treatable Seizures

devSEEK Spotlight Panels
- ❑ Holoprosencephaly
- ❑ Lissencephaly
- ❑ Microcephaly
- ❑ Noonan Syndrome/RASopathies
- ❑ Short Stature

devACT Spotlight Panels
- ❑ Congenital Disorders of Glycosylation
- ❑ Neuronal Ceroid Lipofuscinosis (NCL)
- ❑ Urea Cycle Disorders
- ❑ Vanishing White Matter
- ❑ Zellweger Spectrum Disorder

nucSEEK Spotlight Panels
- ❑ Leigh Syndrome
- ❑ Classic Mitochondrial Disorders

Additional Ordering Instructions

_____

_____

Patient Identification (Required)

Patient Name(First Last/Family) _____

Birth Date _____ Gender: ❑ Male ❑ Female

Mailing Address _____

_____

City, State, Zip _____

Primary Contact (Parent/guardian if patient is a minor, or patient if adult)

Name _____

Home Phone _____ Mobile Phone _____

Email _____

Parental Samples* (Check if sending parent's samples and fill in information)

❑ Mother's Name _____ Birth Date: _____
- ❑ YES / ❑ NO: Mother has similar symptoms as patient (if YES, please describe symptoms on page 2)
- ❑ Different address than patient (please include on page 2)

❑ Father's Name _____ Birth Date _____
- ❑ YES / ❑ NO: Father has similar symptoms as patient (if YES, please describe symptoms on page 2)
- ❑ Different address than patient (please include on page 2)

*HCP authorizes carrier confirmation testing if parental samples and info are provided.

ICD-10 Codes (Required for insurance billing)

Billing Type

❑ Patient Insurance
❑ Government Contract
❑ Self-Pay (a credit card will be required)
❑ Institutional Account

Institutional Account Reference/PO _____

Patient Primary Insurance Information

You MUST provide a photocopy of the front and back of all insurance cards

Please attach additional documents or secondary insurance information as necessary

Subscriber Name _____ Birth Date _____

Relationship to Patient: ❑ Self ❑ Parent ❑ Spouse ❑ Other _____

Insurance Co. Name _____

Member ID # _____ Group ID # _____

Member Services Phone _____

Specimen Collection:

Sample type (check one): ❑ saliva ❑ blood ❑ gDNA ❑ muscle

- ❑ No kit needed - Patient sample has already been collected or has kit
- ❑ Please send a saliva collection kit directly to the patient
- ❑ Please send an assisted saliva collection kit (with sponge) directly to the patient
- ❑ I request that Courtagen schedule a blood draw directly with the patient

Ship Specimens to:
Sample Receiving
Courtagen Diagnostics Laboratory
8 Cabot Road, Suite 2000
Woburn, MA 01801

Sample Collection Date
if not already specified

Physician/Laboratory Contact Information (REQUIRED)

Physician Name _____

Admin Contact _____

NPI/UPIN # _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Healthcare Professional Authorization of Testing & Letter of Medical Necessity (REQUIRED)

I certify that I have discussed with this patient the medical reasons for ordering this test. In addition, I have obtained from this patient all other consents that the laws of my state require in performing genetic testing on patients. I further certify that this test I am ordering is medically necessary. The results of this test will be used in the medical management of this patient and/or for genetic counseling of this patient and his/her family member(s). I have provided genetic counseling to the individual(s) signing above and explained the potential risks, benefits and limitations of receiving incidental findings and answered all of their questions. I understand that Courtagen may contact the patient to obtain required billing and processing information, and that Courtagen reserves the right to decline to process an order for genetic testing if the reasons for testing are not clinically consistent with generally accepted medical necessity guidelines. For Triome tests, if both parental samples are not received within two weeks of the patient's sample, then the epiSEEK Triome test may be replaced by the epiSEEK Comprehensive test, and the devSEEK Triome test may be replaced by the Combined Neurodevelopmental Analysis (devSEEK & devACT tests). **I also authorize Courtagen to submit a letter of medical necessity on my behalf.**

Please Sign & Date

Healthcare Professional Signature **Date**

Courtagen
DIAGNOSTICS LABORATORY

Patient Clinical Information (Required)

Please attach clinical notes and/or complete this form (check applicable findings, describe symptoms, and sign below). Additional details aid test interpretation.

Patient Name: _____ Birth Date: _____

1. Please describe the patient's primary complaint(s) and associated testing abnormalities.
2. Please include any notes or specific clinical questions you would like this test to answer.
3. If patient is a parent or relative for carrier testing, please indicate if patient is affected

Neurological
- ❑ Hypotonia
- ❑ Spasticity
- ❑ Dystonia
- ❑ Chorea
- ❑ Motor tics
- ❑ Ataxia
- ❑ Stroke-like episodes/stroke
- ❑ Peripheral neuropathy
- ❑ Exaggerated startle
- ❑ Clumsiness/incoordination
- ❑ *Other:* _____

Seizures/Epilepsy
- ❑ Infantile/epileptic spasms
  - ❑ West syndrome
  - ❑ Ohtahara syndrome
- ❑ Febrile seizures
  - ❑ Dravet syndrome
- ❑ Status epilepticus
- ❑ Epileptic encephalopathy
- ❑ Generalized seizures
  - ❑ Absence
  - ❑ Tonic-clonic
  - ❑ Myoclonic
  - ❑ Clonic
- ❑ Focal seizures

Cognitive
- ❑ Motor delay
- ❑ Intellectual delay
- ❑ Recurrent encephalopathy
- ❑ Developmental regression
- ❑ Autism/autistic spectrum
- ❑ ADD/ADHD
- ❑ *Other:* _____

Sensory
- ❑ Hearing impairment
- ❑ Vision loss
- ❑ Optic neuropathy
- ❑ Cherry red spot on macula
- ❑ Corneal opacity
- ❑ Glaucoma
- ❑ Retinal abnormality
  type: _____
- ❑ *Other:* _____

Brain Malformation / Abnormal Imaging
- ❑ Corpus callosum agenesis
- ❑ Holoprosencephaly
- ❑ Lissencephaly
- ❑ Cortical dysplasia
- ❑ Heterotopia
- ❑ Hydrocephalus/macrocephaly
- ❑ Brain atrophy
- ❑ Periventricular Leukomalacia
- ❑ Hemimegalencephaly
- ❑ Basal ganglia abnl
- ❑ Tumor
  type: _____

Musculoskeletal
- ❑ Muscle Weakness
- ❑ Rhabdomyalysis
- ❑ Cardiomyopathy
- ❑ Strabismus
- ❑ Ptosis/Ophthalmoplegia
- ❑ Bone disease
- ❑ Joint disease/pain
- ❑ Skeletal abnl/dysplasia
- ❑ *Other:* _____

Functional/Dysautonomic
- ❑ Migraine
- ❑ Abdominal pain
- ❑ Myalgia
- ❑ Other pain condition:
- ❑ GERD
- ❑ Gastroparesis
- ❑ Small bowel disease
- ❑ Lg bowel disease/IBS/constipation
- ❑ Chronic fatigue
- ❑ Urinary retention/urgency
- ❑ Tinnitus
- ❑ Tachycardia
- ❑ Cyclic vomiting
- ❑ Orthostatic tachycardia (POTS)
- ❑ Irritability
- ❑ *Other:* _____

Body Fluid Metabolites
- ❑ Lactic acidosis
- ❑ Ketosis
- ❑ Elevated hepatic transaminases
- ❑ Decreased plasma carnitine
- ❑ Coenzyme Q10 def.
- ❑ Organic acids:
  result: _____
- ❑ Blood acylcarnitines:
  result: _____
- ❑ Other test
  type: _____
  result: _____

Endocrine
- ❑ Growth hormone def.
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Hypoglycemia
- ❑ *Other:* _____

Psychiatric
- ❑ Depression/Bipolar
- ❑ Anxiety/Panic
- ❑ Psychosis
- ❑ *Other:* _____

Organ Systems/Other
- ❑ Liver disease/failure
- ❑ Pancreatitis
- ❑ Bone marrow suppression
- ❑ Renal tubular dysfunction
- ❑ Renal disease/failure
- ❑ Recurrent infections
- ❑ Growth delay/Decreased velocity
- ❑ Hepatosplenomegaly
- ❑ Anemia/cytopathies/thrombocytopenia
- ❑ Dysmorphic features/Coarse facial features
- ❑ Hernias
- ❑ Macroglossia
- ❑ Angiokeratomas
- ❑ Thickening heart valves
- ❑ *Other:* _____

Muscle biopsy
- ❑ Abnormal histology/EM
- ❑ Abnormal enzymology
- ❑ Other test
  type: _____

Inheritance Pattern
- ❑ Father affected
- ❑ Mother affected
- ❑ Sibling affected
- ❑ Probable maternal
- ❑ Sporadic
- ❑ Age of onset:_____
- ❑ *Other:* _____

Other Testing
(e.g. Molecular / Cytogenetics / Microarray / FISH / Other)
Test: _____
Result: _____
_____
_____
_____

Please sign here if clinical information is provided on this form.

Please Sign & Date

_____
Healthcare Professional Signature **Date**

CLINICAL QUESTIONNAIRE

Date:

Patient Name:

Patient DOB:

What clinical signs and symptoms are present in the patient? Please list below:

What relevant laboratory and/or clinical testing has been performed to date? (check all that apply and include copy of results)

- ☐ No other testing has been performed to date
- ☐ Genetic test results
- ☐ Karyotype/chromosomes/FISH
- ☐ Microarray
- ☐ Fragile X syndrome
- ☐ Single gene testing
- ☐ Multigene panel testing
- ☐ Other laboratory studies
- ☐ MRI or other imaging
- ☐ EEG, EMG, EKG or other studies
- ☐ Other:

Is there any family history of illness/disease?

☐ Yes. Please explain below: ☐ No

What medications/dosages is the patient currently taking and what medications/dosages has the patient taken in the past:

What is the indication for the Courtagen testing ordered? (Check all that apply)

- ☐ to establish a genetic etiology for the patient's clinical presentation
- ☐ to predict the possibility of future illness
- ☐ to detect the presence of a carrier state in unaffected individuals
- ☐ to predict response to therapy
- ☐ other, please list:

How will the results of the genetic test, whether positive or negative, impact the future medical management of the patient being tested? (Check all that apply and explain)

☐ Change treatment plan (e.g. medical or surgical decision-making, medication selection or avoidance, or other treatment), please explain:

☐ Change surveillance (e.g. annual echocardiograms or other screening for comorbidities), please explain:

☐ Stop the need for further diagnostic testing, please explain:

☐ Inform on prognosis, please explain:

☐ Provide information for family members, please explain:

Clinician Name:

Clinician Signature: