Neurology Patient Insurance Test Requisition (June 2015)

Patients Requesting Financial Assistance – Patients who meet certain income guidelines may qualify for financial assistance. Please complete the patient identification information and Athena Diagnostics[1] will contact the patient directly to initiate the application process and (for patients where insurance remits to patient only) to collect prepayment.

For any patient of any payer (including Medicare and Medicaid) you should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

athena diagnostics

Fields in red indicate required information

Patient

Insured Patient Information

Complete this requisition for all patients with insurance, including Medicare. Patients with an insurance plan for which Athena Diagnostics is a contracted provider are subject to any co-insurance and deductible of their plan. Athena Diagnostics will bill the patient's insurance for the total price of the test and work on the patient's behalf to file appropriate justifications and/or appeals when applicable. Patients should verify coverage with their health plan prior to testing.

Patient Identification

Patient Name _____ (First) _____ (Last)

Patient ID # (if available) _____

DOB _____ Sex: ☐ Male ☐ Female ☐ Unknown

Last Four Digits of SS# _____

Mailing Address _____

_____

City _____ State _____ Zip _____

Phone #1 _____ ☐ Day ☐ Eve ☐ Cell

Phone #2 _____ ☐ Day ☐ Eve ☐ Cell

Appeal Authorization: In the event of an underpayment or denial by my insurance carrier, I hereby authorize Athena Diagnostics or their designee to appeal to my insurance carrier on my behalf, to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. This authorization shall remain valid until the charges for the orders on this form are paid in full.

Authorization to Release Information and Pay Benefits: I authorize Athena Diagnostics to provide my insurance carrier all information, including test results, concerning my laboratory test(s). I understand that I may be responsible for all charges not covered by my insurance carrier, and I understand that payment is due within thirty (30) days of receipt of your invoice. I authorize and direct that benefits under this claim be paid directly to Athena Diagnostics, and I agree to remit to Athena Diagnostics immediately any payment for these services made directly to me. I acknowledge that the charges for the test(s) ordered by my physician will be withdrawn in the event of cancellation only if such cancellation is executed by the ordering physician and a copy of the written confirmation evidencing this action is provided to Athena prior to the issuance of the test result.

1. Athena Diagnostics and/or designee may perform this appeal on my behalf, but is not obligated to do so.

_____
Patient Signature Date

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

Patient Insurance Information

Please provide a photocopy of the front and back of the insurance card.

Name of Insured _____ (First) _____ (Last)

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Insurance Co. Name _____

Member ID # _____

Group ID # _____

Address _____

City _____ State _____ Zip _____

Phone _____

Does the patient have secondary insurance? ☐ Yes ☐ No

If yes, please attach face sheet and copy of front and back of insurance card.

Physician

Physician/Laboratory Contact Information

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 also be indicated on the test requisition.

Contact Name _____ (First) _____ (Last)

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): 356.8 (ICD-10 G60.8)

Required Physician Information

NPI # _____

Athena Account # (if assigned) _____

Name _____ (First) _____ (Last)

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

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.

Additional Authorized Result Report Recipient

Name _____ (First) _____ (Last)

UPIN # or CLIA # _____

Address _____ (P.O. Box not acceptable)

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Indications for Genetic Testing (Check One)

☒ Diagnostic (symptomatic) ☐ Prenatal ☐ Family Testing

☐ Predictive (asymptomatic) ☐ Carrier

Type of Specimen ☐ Whole Blood ☐ Serum ☐ CSF ☐ Muscle ☐ 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 be indicated on the test requisition.

For Specimen Collection Service,[2] Please Fax this Test Requisition to 610-271-6085.

2. Specimen collection service will work with the patient to obtain phlebotomy services through either a home draw or other laboratory. See online catalog at AthenaDiagnostics.com for complete test specifications and shipping information. Reflex testing will be performed at an additional charge.

Athena Diagnostics Neurology Testing Services (June 2015)

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

Test Code		Pref. Spec.	Min. Vol.	Tube Type
Cerebrovascular Disease (Stroke)				
☐ 421	Complete CADASIL Evaluation* (Notch3 Sequencing)	B	10 mL	L
☐ 442	HTRA1 DNA Sequencing Test* (CARASIL)	B	10 mL	L
☐ 424	COL4A1 DNA Sequencing Test* (CSVD)	B	10 mL	L
☐ **692**	**Complete Cerebral Cavernous Malformation (CCM) Evaluation*** (KRIT1 Seq./Del., CCM2 Seq./Del., PDCD10 Seq./Del.)	B	10 mL	L
☐ **683**	**KRIT1 (CCM1) Evaluation*** (KRIT1 Sequencing/Deletion)	B	10 mL	L
☐ **686**	**CCM2 Evaluation*** (CCM2 Sequencing/Deletion)	B	10 mL	L
☐ **689**	**PDCD10 (CCM3) Evaluation*** (PDCD10 Sequencing/Deletion)	B	10 mL	L
☐ 681	KRIT1 (CCM1) DNA Sequencing Test*	B	10 mL	L
☐ 682	KRIT1 (CCM1) Deletion Test*	B	10 mL	L
☐ 684	CCM2 DNA Sequencing Test*	B	10 mL	L
☐ 685	CCM2 Deletion Test*	B	10 mL	L
☐ 687	PDCD10 (CCM3) DNA Sequencing Test*	B	10 mL	L
☐ 688	PDCD10 (CCM3) Deletion Test*	B	10 mL	L
Dementia				
☐ **178**	**ADmark® Alzheimer's Evaluation*** (ApoE, Phospho-Tau, Total-Tau, Aß42) (Symptomatic for Dementia) (CSF must be in polypropylene tube and arrive on cold pack)	C B	2 mL 10 mL	P L
☐ 109	ADmark® ApoE Genotype Analysis & Interpretation* (Symptomatic for Dementia)	B	10 mL	L
☐ 177	ADmark® Phospho-Tau/Total-Tau/Aß42 CSF Analysis & Interpretation (CSF must be in polypropylene tube and arrive on cold pack or frozen)	C	2 mL	P
☐ **179**	**ADmark® Early-Onset Alzheimer's Evaluation*** (PS-1, APP Seq./Dup., PS-2)	B	10 mL	L
☐ 167	ADmark® PS-1 DNA Sequencing Test*	B	10 mL	L
☐ 168	ADmark® APP DNA Seq./Dup. Test*	B	10 mL	L
☐ 169	ADmark® PS-2 DNA Sequencing Test*	B	10 mL	L
☐ **281**	**Frontotemporal Dementia (FTD) Evaluation*** (MAPT, GRN, C9orf72)	B	10 mL	L
☐ 209	C9orf72 DNA Test*	B	10 mL	L
☐ 204	GRN DNA Sequencing Test*	B	10 mL	L
☐ 205	MAPT DNA Sequencing Test*	B	10 mL	L
☐ **1700**	**Autoimmune Rapidly Progressive Dementia Evaluation** (Hu, MaTa, CV2, Amphiphysin, GAD65, NMDA, VGKC, LGI1, CASPR2)	S	2 mL	R
☐ 1701	Recombx Hu Autoantibody Test (Autoimmune Rapidly Progressive Dementia)*	S	2 mL	R
☐ 1702	Recombx MaTa Autoantibody Test (Autoimmune Rapidly Progressive Dementia)*	S	2 mL	R
☐ 1703	Recombx CV2 Autoantibody Test (Autoimmune Rapidly Progressive Dementia)*	S	2 mL	R
☐ 1704	Amphiphysin Antibody Test (Autoimmune Rapidly Progressive Dementia)*	S	2 mL	R
☐ 1705	GAD65 Autoantibody Test (Autoimmune Rapidly Progressive Dementia)*	S	2 mL	R
☐ 1706	NMDA Receptor Autoantibody Test (Autoimmune Rapidly Progressive Dementia)*	S	2 mL	R
☐ 1707	VGKC Autoantibody Test (Autoimmune Rapidly Progressive Dementia)*	S	2 mL	R
☐ 1708	LGI1 Autoantibody Test (Autoimmune Rapidly Progressive Dementia)*	S	2 mL	R
☐ 1709	CASPR2 Autoantibody Test (Autoimmune Rapidly Progressive Dementia)*	S	2 mL	R
Developmental Disabilities				
☐ **788**	**Primary Microcephaly Evaluation*** (ASPM, MCPH1, WDR62)	B	10 mL	L
☐ 784	ASPM DNA Sequencing Test*	B	10 mL	L
☐ 786	MCPH1 DNA Sequencing Test*	B	10 mL	L
☐ 787	WDR62 DNA Sequencing Test*	B	10 mL	L
☐ 742	SHANK3 DNA Sequencing Test*	B	10 mL	L
☐ 724	SHANK2 DNA Sequencing Test*	B	10 mL	L
☐ 744	PTEN DNA Sequencing Test*	B	5 mL	L
☐ **795**	**Joubert Syndrome Evaluation*** (TMEM67, TMEM216, AHI1, CEP290, NPHP1, CC2D2A)	B	10 mL	L
☐ 792	TMEM67 DNA Sequencing Test*	B	10 mL	L
☐ 789	TMEM216 DNA Sequencing Test*	B	10 mL	L
☐ 790	AHI1 DNA Sequencing Test*	B	10 mL	L
☐ 791	CEP290 DNA Sequencing Test*	B	10 mL	L
☐ 793	NPHP1 DNA Deletion Test*	B	10 mL	L
☐ 794	CC2D2A DNA Sequencing Test*	B	10 mL	L
☐ 737	Smith-Lemli-Opitz Syndrome (DHCR7) DNA Test*	B	5 mL	L
☐ 729	Cohen Syndrome (COH1) DNA Seq. Test*	B	5 mL	L
☐ **153**	**Complete Rett Syndrome Evaluation*** (MECP2 Seq., MECP2 Duplication/Deletion)	B	10 mL	L
☐ 142	Rett Syndrome (MECP2) DNA Seq. Test*	B	10 mL	L
☐ 148	Rett Syndrome (MECP2) Dup./Del. Test*	B	10 mL	L
☐ **773**	**ARX Evaluation*** (ARX DNA Seq., ARX Dup./Del.)	B	10 mL	L
☐ 141	ARX DNA Sequencing Test*	B	10 mL	L
☐ 041	ARX Duplication/Deletion Test*	B	10 mL	L
☐ **785**	**CDKL5 Evaluation*** (CDKL5 Seq., CDKL5 Dup./Del.)	B	10 mL	L
☐ 149	CDKL5 DNA Sequencing Test*	B	10 mL	L
☐ 049	CDKL5 Duplication/Deletion Test*	B	10 mL	L
☐ 771	SYNGAP1 DNA Sequencing Test*	B	10 mL	L
☐ **7540**	**MEF2C Evaluation*** (MEF2C DNA Seq., MEF2C Del.)	B	4 mL	L
☐ 754	MEF2C DNA Sequencing Test*	B	4 mL	L
☐ 077	MEF2C Deletion Test*	B	4 mL	L
☐ **7410**	**FOXG1 Evaluation*** (FOXG1 DNA Seq., FOXG1 Del.)	B	4 mL	L
☐ 740	FOXG1 DNA Sequencing Test*	B	4 mL	L
☐ 074	FOXG1 Deletion Test*	B	4 mL	L
NOTE: Pediatric minimum for all Developmental Disabilities tests is 2 mL.				
Epilepsy				
☐ **5000**	**Epilepsy Advanced Sequencing Evaluation***	B	7 - 10 mL	L
☐ **5001**	**Epilepsy Advanced Sequencing Evaluation – Generalized, Absence, Focal and Myoclonus Epilepsies***	B	6 mL	L
☐ **5002**	**Epilepsy Advanced Sequencing Evaluation – Epileptic Encephalopathies***	B	6 mL	L
☐ **5003**	**Epilepsy Advanced Sequencing Evaluation – Neuronal Migration Disorders***	B	6 mL	L
☐ **5004**	**Epilepsy Advanced Sequencing Evaluation – Epilepsy in X-Linked Intellectual Disability***	B	6 mL	L
☐ **5005**	**Epilepsy Advanced Sequencing Evaluation – Neuronal Ceroid Lipofuscinosis***	B	6 mL	L
☐ **5006**	**Epilepsy Advanced Sequencing Evaluation – Epilepsy Associated with Migraine***	B	6 mL	L
☐ **5007**	**Epilepsy Advanced Sequencing Evaluation – Syndromic Disorders with Epilepsy***	B	6 mL	L
☐ **5008**	**Epilepsy Advanced Sequencing Evaluation – Infantile Spasms***	B	6 mL	L
Please see website for the list of genes in each panel.				
☐ **5100**	**Autoimmune Epilepsy Evaluation** GAD65 Neurological Syndrome, VGKC, CASPR2, LGI1, NMDA (NR1-subunit) Autoantibody Test	S	2 mL	R
☐ 5101	GAD65 Neurological Syndrome Autoantibody Test (Epilepsy) (Single)	S	2 mL	R
☐ 5102	VGKC Autoantibody Test (Epilepsy) (Single)	S	2 mL	R
☐ 5103	CASPR2 Autoantibody Test (Epilepsy) (Single)	S	2 mL	R
☐ 5104	LGI1 Autoantibody Test (Epilepsy) (Single)	S	2 mL	R
☐ 5105	NMDA Receptor (NR1-subunit) Autoantibody Test (Epilepsy) (Single)	S	2 mL	R
☐ **556**	**Complete Tuberous Sclerosis Evaluation*** (TSC1 Seq., TSC1 Del., TSC2 Seq., TSC2 Del.)	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
☐ 524	TSC2 DNA Deletion Test*	B	10 mL	L
☐ 523	TSC Familial DNA Seq. Mutation Evaluation*	B	10 mL	L
	Proband Accession # _____			
	Relationship _____			
☐ **573**	**SCN1A Complete Evaluation*** (SCN1A Sequencing, SCN1A Deletion)	B	10 mL	
☐ 537	SCN1A Deletion Test*	B	10 mL	
☐ **674**	**CSTB (EPM1) Evaluation*** (CSTB (EPM1) DNA Test, CSTB (EPM1) Seq.)	B	10 mL	
☐ 410	CSTB (EPM1) (Unverricht-Lundborg) DNA Test*	B	10 mL	
☐ **797**	**ARX Evaluation*** (ARX Seq., ARX Dup./Del.)	B	10 mL	
☐ **799**	**CDKL5 Evaluation*** (CDKL5 Seq., CDKL5 Dup./Del.)	B	10 mL	
☐ 065	ARX Duplication/Deletion Test*	B	10 mL	
☐ 067	CDKL5 Duplication/Deletion Test*	B	10 mL	
☐ 549	Alexander Disease (GFAP) DNA Seq. Test*	B	10 mL	
☐ 443	POLG DNA Seq. Test* (Alpers Syndrome)	B	10 mL	
NOTE: Pediatric minimum for all Epilepsy tests is 2 mL.				
Family Testing				
☐ 185	Familial DNA Sequence Evaluation* This test detects previously identified sequence variants in at-r family members. This test cannot be applied to the TTR gene. For Familial TSC mutations, please order Code 523.	B	10 mL	
	Proband Accession # _____			
	Relationship _____			
Hearing Loss				
☐ **329**	**Connexin Related Deafness Evaluation*** (Connexin 26, Connexin 30)	B	10 mL	
☐ 321	Connexin 26 DNA Sequencing Test*	B	10 mL	
☐ 319	Connexin 30 DNA Deletion Test*			
Leukodystrophy				
☐ 421	Complete CADASIL Evaluation* (Notch3 Sequencing)	B	10 mL	
☐ **6106**	**Leukoencephalopathy with Vanishing White Matter Evaluation*** (EIF2B1, EIF2B2, EIF2B3, EIF2B4, EIF2B5)	B	10 mL	
☐ 6101	EIF2B1 DNA Sequencing Test*	B	10 mL	
☐ 6102	EIF2B2 DNA Sequencing Test*	B	10 mL	
☐ 6103	EIF2B3 DNA Sequencing Test*	B	10 mL	
☐ 6104	EIF2B4 DNA Sequencing Test*	B	10 mL	
☐ 6105	EIF2B5 DNA Sequencing Test*	B	10 mL	
☐ 6107	ARSA DNA Sequencing Test*	B	10 mL	
☐ 6108	ABCD1 DNA Sequencing Test*	B	10 mL	
☐ **6110**	**PLP1 Evaluation*** (PLP1 Seq., PLP1 Dup.)	B	10 mL	
☐ 6112	PLP1 DNA Sequencing Test*	B	10 mL	
☐ 6111	PLP1 Duplication Test*	B	10 mL	
☐ 6109	GJC2 DNA Sequencing Test*	B	10 mL	
☐ 549	Alexander Disease (GFAP) DNA Seq. Test*	B	10 mL	
Migraine				
☐ **190**	**Hemiplegic Migraine Evaluation*** (CACNA1A, ATP1A2, SCN1A)	B	10 mL	
☐ 187	CACNA1A (FHM1) DNA Test*	B	10 mL	
☐ 188	ATP1A2 (FHM2) DNA Test*			
☐ 189	SCN1A (FHM3) DNA Test* (Exons 3, 23, 26)			
Mitochondrial Disorders				
☐ **575**	**Common Mitochondrial Disorders Evaluation*** (POLG, MELAS, MERRF, NARP)	B	10 mL	
☐ **576**	**Progressive External Ophthalmoplegia (PEO) Evaluation*** (POLG, TWINKLE, ANT1, OPA1, MELAS)	B	10 mL	
☐ **577**	**Mitochondrial Neurogastrointestinal Encephalopathy (MNGIE) Evaluation*** (TYMP, RRM2B, MEL	B	10 mL	
☐ **578**	**Mitochondrial Hepatoencephalopathic Evaluation*** (POLG, DGUOK, MPV17, TWINKLE)	B	10 mL	
☐ **579**	**Mitochondrial Encephalomyopathic Evaluation*** (TK2, RRM2B, POLG)	B	10 mL	
☐ **515**	**LHON mtDNA Evaluation*** (LHON 11778, 3460, 14484)	B	10 mL	
☐ 474	POLG DNA Sequencing Test* (Related to all allelic disorders)	B	10 mL	
☐ 479	TWINKLE (PEO1/C10orf2) DNA Seq. Test* (Related to mtDNA depletion)	B	10 mL	
☐ 466	ANT1 (SLC25A4) DNA Sequencing Test* (Related to mtDNA depletion)	B	10 mL	
☐ 469	OPA1 DNA Sequencing Test* (Related to mtDNA depletion)	B	10 mL	
☐ 484	TYMP DNA Sequencing Test* (Related to mtDNA depletion)	B	10 mL	

Test Code		Pref. Spec.	Min. Vol.	Tube Type
Peripheral Neuropathy: Autoimmune				
☐ **287**	**SensoriMotor Neuropathy Evaluation** (Co-GM1 Quattro®, MAG 'Dual Antigen'®, Hu, GALOP™, Sulfatide)	S	2 mL	R
☐ **263**	**Sensory Neuropathy Evaluation** (MAG 'Dual Antigen'®, Hu, GALOP™, Sulfatide)	S	2 mL	R
☐ **288**	**Motor Neuropathy Evaluation** (Co-GM1 Quattro®, MAG 'Dual Antigen'®)	S	2 mL	R
☐ **289**	**Multifocal Motor Neuropathy Evaluation*** (Co-GM1 Quattro®, PMP22 Dup./Del.)	S B	2 mL 10 mL	R L
☐ 277	Co-GM1 Quattro® Antibody Test	S	2 mL	R
☐ 145	MAG 'Dual Antigen'® Autoantibody Test	S	2 mL	R
☐ 261	GALOP™ Antibody Test	S	2 mL	R
☐ 210	Sulfatide Autoantibody Test	S	2 mL	R
☐ 160	GQ1b Autoantibody Test	S	2 mL	R
☐ 278	GD1a Antibody Test	S	2 mL	R
☐ 272	Co-Asialo Antibody Test	S	2 mL	R
☐ 273	Co-GD1b Antibody Test	S	2 mL	R
☐ 271	Co-GM1 Antibody Test	S	2 mL	R
Peripheral Neuropathy: Hereditary				
☐ **4010**	**CMT Advanced Evaluation – Initial Genetic Assessment** (PMP22 Dup./Del., GJB1 (Cx32), MPZ, MFN2 Seq.)	B	10 mL	L
☐ **4011**	**CMT Advanced Evaluation – Nonprevalent Axonal** (GJB1 (Cx32) Del., NFL, GDAP1, GARS, RAB7, HSPB1, DNM2, YARS, LMNA, TRPV4, HSPB8 Seq.)	B	10 mL	L
☐ **4012**	**CMT Advanced Evaluation – Nonprevalent Demyelinating** (GJB1 (Cx32) Del., EGR2, LITAF, PMP22, PRX, GDAP1, DNM2, YARS SH3TC2, MTMR2, NDRG1, FGD4, FIG4, SBF2 Seq.)	B	10 mL	L
☐ **4013**	**CMT Advanced Evaluation – Nonprevalent** (GJB1 (Cx32) Del., PMP22, EGR2, LITAF, PRX, GDAP1, RAB7, GARS NFL, HSPB1, LMNA, FIG4, SH3TC2, DNM2, YARS, FGD4, NDRG1, TRPV4, HSPB8, MTMR2, SBF2 Seq.)	B	10 mL	L

Test Code		Pref. Spec.	Min. Vol.	Tube Type
☐ **4001**	**CMT Advanced Evaluation – Comprehensive (Reflexive)*** Testing is performed in this order: 1. PMP22 Dup./Del. If negative: 2. Cx32, PMP22, MFN2, MPZ, EGR2, LITAF, PRX, GDAP1, RAB7, GARS, NFL, HSPB1, LMNA, FIG4, SH3TC2, DNM2, YARS, FGD4, NDRG1, TRPV4, HSPB8, MTMR2, SBF2 DNA Seq.	B	15 mL	L
☐ **4002**	**CMT Advanced Evaluation – Dominant, Demyelinating (Reflexive)*** Testing is performed in this order: 1. PMP22 Dup./Del. If negative: 2. MPZ, PMP22 Seq., EGR2, LITAF, DNM2, YARS DNA Seq.	B	15 mL	L
☐ **4003**	**CMT Advanced Evaluation – Dominant, Axonal*** (MFN2, MPZ, RAB7, GARS, NFL, HSPB1, LMNA, DNM2, YARS, TRPV4, HSPB8)	B	15 mL	L
☐ **4004**	**CMT Advanced Evaluation – Recessive, Demyelinating*** (PRX, GDAP1, SBF2, SH3TC2, MTMR2, NDRG1, FGD4, FIG4)	B	15 mL	L
☐ **4005**	**CMT Advanced Evaluation – Dominant (Reflexive)*** Testing is performed in this order: 1. PMP22 Dup./Del. If negative: 2. MFN2, MPZ, PMP22 Seq., EGR2, LITAF, RAB7, GARS, NFL, HSPB1, DNM2, YARS, TRPV4, HSPB8 DNA Seq.	B	15 mL	L
☐ **4006**	**CMT Advanced Evaluation – Recessive*** (PRX, GDAP1, SBF2, LMNA, FIG4, SH3TC2, MTMR2, NDRG1, FGD4)	B	15 mL	L
☐ **4007**	**CMT Advanced Evaluation – Demyelinating (Reflexive)*** Testing is performed in this order: 1. PMP22 Dup./Del. If negative: 2. Cx32, MPZ, PMP22 Seq., EGR2, LITAF, PRX, GDAP1, DNM2, YARS, SH3TC2, MTMR2, NDRG1, FGD4, FIG4, SBF2 DNA Seq.	B	15 mL	L
☐ **4008**	**CMT Advanced Evaluation – Axonal*** (MFN2, Cx32, MPZ, RAB7, GARS, NFL, HSPB1, GDAP1, DNM2, YARS, LMNA, TRPV4, HSPB8)	B	15 mL	L

Test Code		Pref. Spec.	Min. Vol.	T T
Individual CMT Tests:		B	10 mL	
☐ 144	TRPV4*	☐ 463	HSPB8*	
☐ 354	MTMR2*	☐ 164	SBF2*	
☐ 394	NDRG1*	☐ 208	FGD4*	
☐ 253	DNM2*	☐ 468	YARS*	
☐ 221	GDAP1 (CMT2K, 4A)*	☐ 222	LITAF/SIMPLE (CMTIC	
☐ 223	MFN2 (CMT2A2)*	☐ 239	Periaxin (CMT4F)*	
☐ 247	PMP22 Seq.*	☐ 248	EGR2 (CMT1D)*	
☐ 249	NFL (CMT2E, 1F)*	☐ 131	PMP22 Dup./Del. (CMT	
☐ 134	MPZ (CMT1B, 2I, 2J)*	☐ 226	LMNA (CMT2B1, 4C1)*	
☐ 224	SH3TC2 (CMT4C)*	☐ 227	RAB7 (CMT2B)*	
☐ 225	FIG4 (CMT4J)*	☐ 228	GARS (CMT2D)*	
☐ 143	Cx32 Seq./Del. (CMTX)*	☐ 229	HSPB1 (CMT2F)*	
☐ **243**	**Complete HNPP Evaluation*** (PMP22 Sequencing, PMP22 Dup./Del.)	B	20 mL	
☐ **245**	**Congenital Hypomyelination Evaluation*** (MPZ, EGR2)	B	15 mL	
☐ **296**	**Entrapment Neuropathy Evaluation*** (PMP22 Seq., PMP22 Dup./Del., TTR)	B	15 mL	
☐ 235	Amyloidosis Evaluation* (TTR)	B	10 mL	
☐ 691	**Early-Onset HSAN Evaluation*** (NTRK1 and WNK1)	B	10 mL	
☐ 698	**Late-Onset HSAN Evaluation*** (SPTLC1 and SPTLC2)	B	10 mL	
☐ 551	SPTLC1 (HSAN I) DNA Sequencing Test*	B	10 mL	
☐ 552	SPTLC2 (HSAN I) DNA Sequencing Test*	B	10 mL	
☐ 553	WNK1 (HSAN II) DNA Sequencing Test*	B	10 mL	
☐ 659	NTRK1 (HSAN IV) DNA Sequencing Test*	B	10 mL	
☐ 660	ATL1 (HSAN I) DNA Sequencing Test*	B	10 mL	
☐ 719	SEPT9 (HNA) DNA Sequencing Test*	B	10 mL	

*Medicare ABN Required

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 be indicated on the test requisition.

Specimen Type

C – CSF
B – Blood
S – Serum
M – Muscle Tissue

Tube Type

P – Polypropylene CSF Transfer Tube
R – Red
L – Lavender
C – Cryovial
** CSF must be collected in a tube n containing additives.

Athena Diagnostics Client Service Representatives are available from 8:30am to 6:30pm Eastern Time (U.S.). Customers in the U.S. and Canada please call toll-free

800-394-4493

(Non-U.S. customers please call 508-756-2886 or fax 774-843-3721.)

athena diagnostics®

200 Forest Street, 2nd Floor
Marlborough, MA 01752 • AthenaDiagnostics.com

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

:e: Test requisitions become outdated. For the most accurate and up-to-date test offering, please visit AthenaDiagnostics.com.

athena diagnostics

Code		Pref. Spec.	Min. Vol.	Tube Type
486	RRM2B DNA Sequencing Test* (Related to mtDNA depletion)	B	10 mL	L
487	DGUOK DNA Sequencing Test* (Related to mtDNA depletion)	B	10 mL	L
488	MPV17 DNA Sequencing Test* (Related to mtDNA depletion)	B	10 mL	L
489	TK2 DNA Sequencing Test* (Related to mtDNA depletion)	B	10 mL	L
517	MELAS mtDNA Evaluation* (MELAS 3243, 3271, 3252, 3256, 3291, 13513)	B	10 mL	L
518	MERRF mtDNA Evaluation* (MERRF 8344, 8356, 8296, 8363)	B	10 mL	L
516	NARP mtDNA Evaluation* (NARP 8993)	B	10 mL	L
324	PDHA1 DNA Sequencing Test*	B	10 mL	L
tor Neuron Diseases				
655	**Complete Hereditary Spastic Paraplegia Evaluation*** (Includes all individual HSP DNA tests, see below.)	B	20 mL	L
653	**Autosomal Dominant Hereditary Spastic Paraplegia Evaluation*** (SPG3A, SPG4, SPG4 Del., SPG6, SPG8, SPG17, SPG31, KIF5A (SPG10), REEP1 (SPG31) Del.)	B	20 mL	L
654	**Autosomal Recessive Hereditary Spastic Paraplegia Evaluation*** (SPG7, SPG11, CYP7B1 (SPG5), Spastizin/ZFYVEZ6 (SPG15))	B	10 mL	L
ividual HSP DNA Tests:		B	10 mL	L
530	Spastin (SPG4)* ☐ 532 NIPA1 (SPG6)*			
531	Atlastin (SPG3A)* ☐ 533 Strumpellin (SPG8)*			
529	REEP1 (SPG31 Seq.)* ☐ 632 Paraplegin (SPG7)*			
561	Spastin (SPG4 Del.)* ☐ 633 Spatacsin (SPG11)*			
531	BSCL2 (SPG17)* ☐ 612 CYP7B1 (SPG5A)*			
513	KIF5A (SPG10)* ☐ 665 REEP1 (SPG31 Del.)*			
514	Spastizin/ZFYVE26 (SPG15)*			
215	**Complete SMA Evaluation (Reflexive)*** This is a reflexive test. Tests will be run in succession until either a positive result is detected or the profile is completed. Testing is performed in this order: 1. SMN1 Del.; 2. SMN1 Seq.; 3. IGHMBP2 (SMARD), UBE1 Exon15 (XLSMA)	B	2 - 4 mL	L
214	**SMA Plus (Reflexive)*** This is a reflexive test. Tests will be run in succession until either a positive result is detected or the profile is completed. Testing is performed in this order: 1. SMN1 Del.; 2. SMN1 Seq.	B	2 - 4 mL	L
111D	Spinal Muscular Atrophy Deletion - Diagnostic* (including SMN2 Copy Number)	B	2 - 4 mL	L
211	Spinal Muscular Atrophy - SMN1 DNA Seq. Test* (only order if deletion testing has already been performed)	B	2 - 4 mL	L
212	Spinal Muscular Atrophy with Respiratory Distress (SMARD) IGHMBP2 DNA Seq. Test*	B	2 - 4 mL	L
213	X-Linked Spinal Muscular Atrophy (XLSMA) UBE1 DNA Sequencing Test* (Exon 15 only)	B	2 - 4 mL	L
444	Spinal Muscular Atrophy - Carrier SMN1 Del. Test*	B	2 - 4 mL	L
117	Kennedy's Disease (SBMA) DNA Test*	B	10 mL	L
643	**Complete ALS Evaluation*** (C9orf72, SOD1, OPTN, VCP, UBQLN2, FUS, TARDBP, ANG, FIG4)	B	20 mL	L
570	C9orf72 DNA Test*	B	10 mL	L
520	SOD1 DNA Sequencing Test*	B	10 mL	L
509	OPTN DNA Sequencing Test*	B	10 mL	L
510	VCP DNA Sequencing Test*	B	10 mL	L
511	UBQLN2 DNA Sequencing Test*	B	10 mL	L
519	FUS DNA Sequencing Test*	B	10 mL	L
521	TARDBP DNA Sequencing Test*	B	10 mL	L
522	ANG DNA Sequencing Test*	B	10 mL	L
vement Disorders				
696	**Complete Ataxia Evaluation*** (Includes all individual Ataxia genes, see below.)	B	20 mL	L
697	**Autosomal Dominant Ataxia Evaluation*** (SCA1, 2, 3, 5, 6, 7, 8, 10, 12, 13, 14, 17, 28, DRPLA)	B	20 mL	L
693	**Autosomal Recessive Ataxia Evaluation*** (APTX, SETX, SIL1, POLG1, TTPA, FRDA/FXN Seq., FRDA/FXN Expansion)	B	20 mL	L
ividual Ataxia DNA Tests:		B	10 mL	L
371	SCA1* ☐ 672 SCA2* ☐ 105 SCA3*			
575	SCA5* ☐ 373 SCA6* ☐ 677 SCA7*			
384	SCA8* ☐ 387 SCA10* ☐ 285 SCA12*			

Test Code		Pref. Spec.	Min. Vol.	Tube Type
☐ 284	SCA13* ☐ 593 SCA14* ☐ 388 SCA17*			
☐ 673	SCA28* ☐ 493 APTX* ☐ 401 DRPLA*			
☐ 594	SETX* ☐ 383 POLG1 (MIRAS)*			
☐ 282	SIL1 (MSS)* ☐ 283 TTPA (AVED)*			
☐ 348	FRDA/FXN Seq.* ☐ 119 FRDA/FXN Expansion*			
☐ **349**	**Friedreich's Ataxia Evaluation*** (FRDA/FXN Seq., FRDA/FXN Expansion)	B	10 mL	L
☐ **353**	**Complete Ataxia-Telangiectasia (ATM) Evaluation*** (ATM Seq., ATM Dup./Del.)	B	10 mL	L
☐ 351	Ataxia-Telangiectasia (ATM) DNA Seq. Test*	B	10 mL	L
☐ 352	Ataxia-Telangiectasia (ATM) DNA Dup./Del. Test*	B	10 mL	L
☐ **402**	**Chorea Differential Evaluation*** (DRPLA, HD)	B	20 mL	L
☐ 116	Huntington's Disease DNA Test*	B	10 mL	L
☐ **639**	**Primary Dystonia Evaluation*** (DYT1, THAP1)	B	10 mL	L
☐ 626	Dystonia (DYT1) DNA Test*	B	10 mL	L
☐ 618	THAP1 (DYT6) DNA Sequencing Test*	B	10 mL	L
☐ **629**	**Complete Dopa-Responsive Dystonia (DYT5) Evaluation*** (GCH1 Seq., GCH1 Del., TH Seq.)	B	10 mL	L
☐ 637	GCH1 DNA Sequencing Test* (DYT5)	B	10 mL	L
☐ 638	GCH1 Deletion Test (DYT5)*	B	10 mL	L
☐ 634	TH DNA Sequencing Test (DYT5)*	B	10 mL	L
☐ 624	SGCE DNA Sequencing Test (DYT11)*	B	10 mL	L
☐ 627	SGCE Deletion Test (DYT11)*	B	10 mL	L
☐ 617	MR-1 (PNKD) DNA Sequencing Test*	B	10 mL	L
☐ **588**	**Complete Parkinsonism Evaluation*** (LRRK2, PARK2, PINK1, PARK7, SNCA)	B	10 mL	L
☐ 558	LRRK2 DNA Sequencing Test*	B	10 mL	L
☐ 559	PARK2 (Parkin) DNA Sequencing Test*	B	10 mL	L
☐ 040	PARK2 (Parkin) Duplication/Deletion Test*	B	10 mL	L
☐ 542	PINK1 DNA Sequencing Test*	B	10 mL	L
☐ 058	PINK1 Deletion Test*	B	10 mL	L
☐ 554	PARK7 (DJ1) DNA Sequencing Test*	B	10 mL	L
☐ 047	PARK7 (DJ1) Deletion Test*	B	10 mL	L
☐ 557	Alpha Synuclein (SNCA) DNA Seq. Test*	B	10 mL	L
☐ 059	Alpha Synuclein (SNCA) Dup./Del. Test*	B	10 mL	L
☐ 666	PRRT2 (Dyskinesia/IC) DNA Seq. Test*	B	10 mL	L
Multiple Sclerosis				
☐ 112	NAbFeron® (IFN-ß) Neutralizing Antibody Test	S	2 mL	R
☐ 197	TYSABRI® (Natalizumab) Antibody Test (must arrive on cold pack)	S	2 mL	R
☐ 193	Neuromyelitis Optica (NMO) Autoantibody Test	S	2 mL	R
Myasthenia Gravis				
☐ 482	MuSK Quantitative Titers Antibody Test	S	2 mL	R
☐ 483	AChR/MuSK Reflexive Antibody Test (Now with MuSK quantitative titers levels)	S	2 mL	R
☐ 1480	Titin Autoantibody Test	S	2 mL	R
Neuromuscular Disorders				
☐ **5501**	**Muscular Dystrophy Advanced Evaluation****	B	10 mL	L
☐ **5502**	**Congenital Muscular Dystrophy Advanced Sequencing Evaluation****	B	10 mL	L
☐ **5503**	**Congenital Myopathy Advanced Sequencing Evaluation****	B	10 mL	L
☐ **5504**	**Distal Myopathy Advanced Sequencing Evaluation****	B	10 mL	L
☐ **5505**	**Myofibrillar Myopathy Advanced Sequencing Evaluation****	B	10 mL	L
☐ **5506**	**Myotonic Syndromes Advanced Sequencing Evaluation****	B	10 mL	L
☐ **5507**	**Periodic Paralysis Advanced Sequencing Evaluation****	B	10 mL	L
☐ **5508**	**Malignant Hyperthermia Advanced Sequencing Evaluation****	B	10 mL	L
☐ **5518**	**Emery-Dreifuss Muscular Dystrophy Advanced Sequencing Evaluation****	B	6 mL	L
☐ **5519**	**Limb Girdle Muscular Dystrophy Advanced Evaluation****	B	6 mL	L
☐ **5511**	**Congenital Myasthenic Syndrome Advanced Sequencing Evaluation*****	B	10 mL	L
☐ **5530**	**DMD Evaluation****	B	6 mL	L
☐ 5531	DMD Duplication/Deletion**	B	6 mL	L
☐ 183	Partial DMD DNA Sequencing Only*	B	10 mL	L
☐ 100	Dystrophin Test	M	10 mg	C

Test Code		Pref. Spec.	Min. Vol.	Tube Type
☐ **207**	**Early-Onset Myotonia Evaluation*** (DM1, CLCN1, SCN4A)	B	10 mL	L
☐ 108	DM1 DNA Test*	B	10 mL	L
☐ 110	DM2 DNA Test* (DM2 testing is not recommended for patients with early onset myotonic dystrophy)			
☐ 128	CLCN1 DNA Test*			
☐ 146	SCN4A DNA Test*			
☐ **494**	**Neuromyotonia Evaluation** (CASPR2, VGKC Antibody Tests)	S	2 mL	R
☐ **585**	**CAPN3 Evaluation*** (includes CAPN3 Seq., CAPN3 Del.)	B	10 mL	L
Individual Limb Girdle Muscular Dystrophy Tests:		B	10 mL	L
☐ 562	FKRP* ☐ 565 LMNA* ☐ 566 CAV3*			
☐ 582	Sarcoglycan A Deletion Test*			
☐ 583	Sarcoglycan G Deletion Test*			
☐ 584	CAPN3 Deletion Test*			
☐ 561	Dysferlin Protein Blood Test* (must arrive on cold pack)	B	15 mL	L
☐ 571	Dysferlin Sequencing Test*	B	10 mL	L
☐ 405	FSHD Southern Blot Test*	B	20 mL	L
☐ 5905	FSHD Molecular Combing Test*	B	10 mL	L
☐ 300	OPMD DNA Test*	B	10 mL	L
☐ **490**	**Optic Atrophy Evaluation*** (OPA1)	B	20 mL	L
Neuro-Oncology				
☐ **648**	**Neurofibromatosis Type 1 (NF1) Evaluation*** (NF1 Sequencing, NF1 Deletion)	B	10 mL	L
☐ **645**	**Neurofibromatosis Type 2 (NF2) Evaluation*** (NF2 Seq., NF2 Dup./Del.)	B	10 mL	L
☐ 646	Neurofibromatosis Type 1 DNA Sequencing Test*	B	10 mL	L
☐ 647	Neurofibromatosis Type 1 Deletion Test*	B	10 mL	L
☐ 635	Neurofibromatosis Type 2 DNA Sequencing Test*	B	10 mL	L
☐ 644	Neurofibromatosis Type 2 Duplication/Deletion Test*	B	10 mL	L
Note: Additional specimens accepted. Please contact Lab Director.				
Paraneoplastic & Other Antibody Disorders of the CNS				
☐ **4500**	**Paraneoplastic Neurological Syndromes Initial Assessment (PNS-IA)** (Hu, Yo, CV2, MaTa, Ri, Amphiphysin)	S or C	2 mL 2 mL	R P**
☐ **467**	**NeoComplete Paraneoplastic Evaluation with Recombx® (Reflexive)** Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, VGCC, VGKC, Amphiphysin, gnAChR, NR1, GAD65 Neurological Syndrome, LGI1, CASPR2.	S	2 mL	R
☐ **438**	**NeoCerebellar Degeneration Paraneoplastic Evaluation with Recombx®** (Hu, Yo, Zic4, CV2, MaTa, Ri, Amphiphysin, GAD65 Neurological Syndrome)	S	2 mL	R
☐ **447**	**NeoEncephalitis Paraneoplastic Evaluation with Recombx®** (Hu, CV2, MaTa, VGKC, Amphiphysin, NR1, GAD65 Neurological Syndrome, LGI1, CASPR2)	S	3 mL	R
☐ **436**	**NeoSensory Neuropathy Paraneoplastic Evaluation with Recombx®** (Hu, CV2, Amphiphysin)	S	2 mL	R
☐ **494**	**Neuromyotonia Evaluation** (CASPR2, VGKC)	S	2 mL	R
Individual Recombx® Antibody Tests:		S	2 mL	R
☐ 118	CAR ☐ 123 CV2 ☐ 120 Hu			
☐ 122	MaTa ☐ 115 Ri ☐ 125 Yo ☐ 127 Zic4			
☐ 449	LGI1 Antibody Test	S	2 mL	R
☐ 499	CASPR2 Antibody Test	S	2 mL	R
☐ 419	NMDA Receptor (NR1-subunit) Antibody Test	S	2 mL	R
☐ 422	GAD65 Neurological Syndrome Antibody Test	S	2 mL	R
☐ 475	LEMS (VGCC) Antibody Test	S	2 mL	R
☐ 485	VGKC Antibody Test	S	2 mL	R
☐ 427	Amphiphysin Antibody Test	S	2 mL	R
☐ 428	Ganglionic AChR (gnAChR) Antibody Test	S	2 mL	R

*Medicare ABN Required **Test Available Feburary 2, 2