Please tear at perforation

Athena Diagnostics Client Test Requisition (May 2012)

athena diagnostics®

***Indicates required information**

Complete this requisition for direct billing to hospitals, laboratories or clinics. Direct client billing is the most efficient way to order from Athena. Direct billing eliminates the need for your patients to provide Athena with their billing and insurance information. This can simplify the ordering process and avoid delay.

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

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

Who Should Athena 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-9 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

DOB*_____ ☐ Female

Age*_____ ☐ Unknown

Mailing Address*_____

_____

City*_____ State*_____ Zip*_____

Phone #1*_____ ☐ Day ☐ Eve ☐ Cell

Phone #2*_____ ☐ Day ☐ Eve ☐ Cell

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) ☐ Clinical Study ☐ Prenatal ☐ Predictive (asymptomatic) ☐ Carrier ☐ Other Research

Warranty of Informed Consent

Testing Authorization: I warrant that this test was ordered and is either: 1) for the purpose of diagnosing or detecting an existing disease, illness, impairment, symptom or disorder, or 2) that if it is not for such purpose, I have obtained the appropriate prior written consent. 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), and includes: a) a statement of the purpose and description of the test; b) a statement that prior to signing the consent form, the consenting person discussed with the medical practitioner ordering the test the reliability of positive or negative test results and the level of certainty that a positive test result for that disease or condition serves as a predictor of such disease; c) a statement that the consenting person was informed about the availability and importance of further testing, physician consultation and genetic counseling, and provided with written information identifying a genetic counselor or medical geneticist from whom the consenting person might obtain such counseling; d) a general description of each specific disease or condition tested for; and e) the person or persons to whom the test results may be disclosed as indicated above.

_____
Medical Practitioner Signature*

Type of Specimen ☐ Whole Blood ☐ Serum ☐ CSF ☐ Buccal Swabs ☐ Muscle ☐ Plasma ☐ CVS: Direct ☐ CVS: Cultured
☐ Amniotic Fluid: Direct ☐ 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 should also be indicated on the test requisition.

Athena Diagnostics Testing Services (April 2012)

Not all available tests are listed here. Please see our ca

Important: Please be sure to write in test

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)	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
Developmental Disabilities				
☐ 783	180K WholeGenome Chromosomal Microarray Analysis			
☐ 782	60K WholeGenome Chromosomal Microarray Analysis			

WholeGenome Microarray Specimen Requirement:

10 mL whole blood drawn in a lavender top tube (EDTA)

AND

10 mL whole blood drawn in a green top tube

Pediatric minimum: 4 mL in each tube

Indication for Study (MUST check one or more below):

- ☐ Developmental Delay:
  - ☐ Mild ☐ Moderate ☐ Severe
- ☐ Mental Retardation:
  - ☐ Mild ☐ Moderate ☐ Severe
- ☐ Autistic Spectrum
- ☐ Failure to Thrive
- ☐ Trisomy 13
- ☐ Multiple Congenital Anomalies
- ☐ Infertility
- ☐ Dysmorphic Features
- ☐ Trisomy 18
- ☐ Fetal Demise
- ☐ Trisomy 21
- ☐ Klinefelter Syndrome
- ☐ Turner Syndrome
- ☐ Testicular Failure
- ☐ Multiple Miscarriages (#_____)
- ☐ Seizures
- ☐ Ambiguous Genitalia
- ☐ Other:_____
- ☐ Family History _____

Previous Cytogenetic Results (if applicable):

_____

Family Members Studied at Athena:

_____

_____

Proband Accession #: _____

NOTE: Athena is a member of the International Standard Cytogenomic Array Consortium (ISCA) and provides de-identified, HIPAA-compliant genomic results to the National Center for Biotechnology Information (NCBI) database. The NCBI is a division of the National Institutes of Health (NIH) and serves the mission of advancing our understanding of human genetics. Patients may withdraw consent to use their data by calling 1-800-394-4493 option 2.

Test Code		Pref. Spec.	Min. Vol.	Tube Type
☐ **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
☐ **769**	**Autism Spectrum Disorders Evaluation** (CNTNAP2, SHANK3, SHANK2, PTCHD1)	B	10 mL	L
☐ 741	CNTNAP2 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
☐ 768	PTCHD1 DNA Sequencing Test	B	10 mL	L
☐ 744	PTEN DNA Sequencing Test	B	5 mL	L
☐ 104	Fragile X (FMR1) DNA Test	B	10 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
☐ **753**	**Smith-Magenis (RAI1) Reflexive Evaluation** Testing is performed in this order: 1. RAI1 Deletion; 2. RAI1 Sequencing	B	5 mL	L
☐ 751	Smith-Magenis (RAI1) Deletion Test	B	5 mL	L
☐ 752	Smith-Magenis (RAI1) Sequencing Test	B	5 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**	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. and 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
☐ 630	Norrie Disease DNA Test	B	20 mL	L
NOTE: Pediatric minimum for all Developmental Disabilities tests is 2 mL.				
Epilepsy				
☐ **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 Proband Accession #_____ Relationship _____	B	10 mL	L
☐ **507**	**Female Febrile Seizures Evaluation** (PCDH19 Seq., SCN1A Seq., SCN1A Del., SCN1B Seq., GABRG2 Seq.)	B	10 mL	L
☐ **548**	**Febrile Seizures Evaluation** (SCN1A Seq., SCN1A Del., SCN1B Seq., GABRG2 Seq.)	B	10 mL	L
☐ **573**	**SCN1A Complete Evaluation** (SCN1A Sequencing, SCN1A Deletion)	B	10 mL	L
☐ 509	PCDH19 (EFMR) DNA Sequencing Test	B	10 mL	L
☐ 535	SCN1A DNA Sequencing Test	B	10 mL	L
☐ 537	SCN1A Deletion Test	B	10 mL	L
☐ 538	SCN1B DNA Sequencing Test	B	10 mL	L
☐ 544	GABRG2 DNA Sequencing Test	B	10 mL	L
☐ **699**	**Myoclonus Epilepsy Evaluation** (CSTB (EPM1) DNA Test, CSTB (EPM1) Seq., EPM2A, EPM2B, MERRF, EFHC1, SCARB2)	B	20 mL	L
☐ **674**	**CSTB (EPM1) Evaluation** (CSTB (EPM1) DNA Test, CSTB (EPM1) Seq.)	B	10 mL	L
☐ **415**	**Lafora Disease Evaluation** (EPM2A, EPM2B)	B	10 mL	L
☐ 410	CSTB (EPM1) (Unverricht-Lundborg) DNA Test	B	10 mL	L

Test Code		Pref. Spec.	Min. Vol.	Tube Type
☐ 671	CSTB (EPM1) DNA Sequencing Test	B	10 mL	L
☐ 411	EPM2A DNA Test	B	10 mL	L
☐ 412	EPM2B DNA Test	B	10 mL	L
☐ **781**	**Early Infantile Epileptic Encephalopathy Evaluation** STXBP1, ARX Seq. and Dup/Del., CDKL5 Seq. and Dup./Del	B	10 mL	L
☐ **797**	**ARX Evaluation** ARX Seq., ARX Dup./Del.	B	10 mL	L
☐ **799**	**CDKL5 Evaluation** CDKL5 Seq., CDKL5 Dup./Del.	B	10 mL	L
☐ 778	STXBP1 DNA Sequencing Test	B	10 mL	L
☐ 657	ARX DNA Sequencing Test	B	10 mL	L
☐ 065	ARX Duplication/Deletion Test	B	10 mL	L
☐ 678	CDKL5 DNA Sequencing Test	B	10 mL	L
☐ 067	CDKL5 Duplication/Deletion Test	B	10 mL	L
☐ 798	SCARB2 DNA Sequencing Test	B	10 mL	L
☐ 549	Alexander Disease (GFAP) DNA Seq. Test	B	10 mL	L
☐ 441	SLC2A1 (GLUT1-DS) DNA Seq. Test	B	10 mL	L
☐ 545	KCNQ2 (BFNC) DNA Sequencing Test	B	10 mL	L
☐ 572	KCNJ10 (EAST Syndrome) DNA Seq. Test	B	10 mL	L
☐ 443	POLG DNA Seq. Test (Alpers Syndrome)	B	10 mL	L
☐ **547**	**ADNFLE Evaluation** (CHRNA4, CHRNB2)	B	10 mL	L
☐ 417	EFHC1 (JME) DNA Sequencing Test	B	10 mL	L
☐ 546	CHRNA4 DNA Sequencing Test	B	10 mL	L
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-risk family members. This test cannot be applied to the TTR gene. For Familial TSC mutations, please order Code 523. Proband Accession #_____ Relationship _____	B	10 mL	L
Hearing Loss				
☐ **329**	**Connexin Related Deafness Evaluation** (Connexin 26, Connexin 30)	B	10 mL	L
☐ 321	Connexin 26 DNA Sequencing Test	B	10 mL	L
☐ 319	Connexin 30 DNA Deletion Test			
☐ 327	OtoDx™ Aminoglycoside Hypersensitivity Test	B	10 mL	L
Hereditary Motor Neuron Diseases				
☐ **655**	**Complete Hereditary Spastic Paraplegia Evaluation** (Includes all individual HSP DNA tests, see below.)	B	10 mL	L
☐ **653**	**Autosomal Dominant Hereditary Spastic Paraplegia Evaluation** (SPG3A, SPG4, SPG4 Del., SPG6, SPG8, SPG17, SPG31 KIF5A (SPG10), REEP1 (SPG31) Del.)	B	10 mL	L
☐ **654**	**Autosomal Recessive Hereditary Spastic Paraplegia Evaluation** (SPG7, SPG11, CYP7B1 (SPG5) and Spastizin/ZFYVEZ6 (SPG15))	B	10 mL	L
Individual 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)	
☐ 661	Spastin (SPG4 Del.)	☐ 633	Spatacsin (SPG11)	
☐ 631	BSCL2 (SPG17)	☐ 612	CYP7B1 (SPG5A)	
☐ 613	KIF5A (SPG10)	☐ 665	REEP1 (SPG31 Del.)	
☐ 614	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 Deletion; 2. SMN1 Sequencing; 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 Deletion; 2. SMN1 Sequencing	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 Sequencing Test (only order if deletion testing has already been performed)	B	2-4 mL	L

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

talog or website for complete offering, as well as CPT codes for each test.

code and test name in the Tests Ordered section on front.

athena diagnostics

Test Code		Pref. Spec.	Min. Vol.	Tube Type
☐ 212	Spinal Muscular Atrophy with Respiratory Distress (SMARD) IGHMBP2 DNA Sequencing 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
☐ **448**	**SMA Carrier Plus (Reflexive)** Carrier testing performed in this order: 1. SMN1 Deletion; 2. SMN1 Sequencing	B	2-4 mL	L
☐ 444	Spinal Muscular Atrophy – Carrier SMN1 Deletion 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	10 mL	L
☐ 670	C9ORF72 DNA Test	B	10 mL	L
☐ 620	SOD1 DNA Sequencing Test	B	10 mL	L
☐ 609	OPTN DNA Sequencing Test	B	10 mL	L
☐ 610	VCP DNA Sequencing Test	B	10 mL	L
☐ 611	UBQLN2 DNA Sequencing Test	B	10 mL	L
☐ 619	FUS DNA Sequencing Test	B	10 mL	L
☐ 621	TARDBP DNA Sequencing Test	B	10 mL	L
☐ 622	ANG DNA Sequencing Test	B	10 mL	L
Migraine				
☐ **190**	**Hemiplegic Migraine Evaluation** (CACNA1A, ATP1A2, SCN1A)	B	10 mL	L
☐ 187	CACNA1A (FHM1) DNA Test	B	10 mL	L
☐ 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	L
☐ **576**	**Progressive External Ophthalmoplegia (PEO) Evaluation** (POLG, TWINKLE, ANT1, OPA1, MELAS)	B	10 mL	L
☐ **577**	**Mitochondrial Neurogastrointestinal Encephalopathy (MNGIE) Evaluation** (TYMP, RRM2B, MELAS)	B	10 mL	L
☐ **578**	**Mitochondrial Hepatoencephalopathic Evaluation** (POLG, DGUOK, MPV17, TWINKLE)	B	10 mL	L
☐ **579**	**Mitochondrial Encephalomyopathic Evaluation** (TK2, RRM2B, POLG)	B	10 mL	L
☐ **500**	**Mitochondrial Enzyme Deficiency Myopathy Evaluation** (COX; Rotenone sensitive NADH reductase; Succinate dehydrogenase; Total protein; NADH dehydrogenase; Citrate synthase; Succinate-cytochrome c reductase)	M	100 mg	C
☐ **515**	**LHON mtDNA Evaluation** (LHON 11778, 3460, 14484)	B	10 mL	L
☐ 514	KSS/CPEO mtDNA Profile	M	100 mg	C
☐ 474	POLG DNA Sequencing Test (Related to all allelic disorders)	B	10 mL	L
☐ 479	TWINKLE (PEO1/C10orf2) DNA Sequencing Test (Related to mtDNA depletion)	B	10 mL	L
☐ 466	ANT1 (SLC25A4) DNA Sequencing Test (Related to mtDNA depletion)	B	10 mL	L
☐ 469	OPA1 DNA Sequencing Test (Related to mtDNA depletion)	B	10 mL	L
☐ 484	TYMP DNA Sequencing Test (Related to mtDNA depletion)	B	10 mL	L
☐ 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

Test Code		Pref. Spec.	Min. Vol.	Tube Type
Movement 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
Individual Ataxia DNA Tests:		B	10 mL	L
☐ 371 SCA1	☐ 672 SCA2	☐ 105 SCA3		
☐ 675 SCA5	☐ 373 SCA6	☐ 677 SCA7		
☐ 384 SCA8	☐ 387 SCA10	☐ 285 SCA12		
☐ 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 Sequencing, 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 Sequencing Test	B	10 mL	L
☐ 352	Ataxia-Telangiectasia (ATM) DNA Duplication/Deletion 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 Sequencing, GCH1 Deletion, TH Sequencing)	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
☐ 106	FXTAS DNA 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
Multiple Sclerosis				
☐ 112	NAbFeron® (IFN-ß) Neutralizing Antibody Test	S	2 mL	R
☐ 194	BAbScreen®/NAbFeron® (IFN-ß) Antibody Test (Binding Antibody positive confirmed by NAbFeron® 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
Neuromuscular Disorders				
☐ **586**	**Male Muscular Dystrophy Reflexive Evaluation** 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. DMD Deletion/Duplication; 2. DMD Sequencing; 3. Limb Girdle Muscular Dystrophy Evaluation.	B	15 mL	L

Test Code		Pref. Spec.	Min. Vol.	Tube Type
☐ **181**	**Complete DMD Evaluation – Males**	B	10 mL	L
☐ **182**	**Complete DMD Evaluation – Females**	B	10 mL	L
☐ 101	Partial DMD Del./Dup. only – Males	B	10 mL	L
☐ 103	Partial DMD Del./Dup. only – Females	B	10 mL	L
☐ 183	Partial DMD DNA Sequencing Only	B	10 mL	L
☐ 100	Dystrophin Test	M	10 mg	C
☐ **295**	**Complete Congenital Muscular Dystrophy (CMD) Evaluation** (FKRP, FCMD, LAMA2, POMGNT, POMT1, POMT2, COL6A1, COL6A2, COL6A3) (Founder mutation not available for FCMD)	B	2-4 mL	L
☐ **237**	**Syndromic Congenital Muscular Dystrophy (CMD) Evaluation** (POMT1, POMT2, POMGNT1, FCMD)	B	2-4 mL	L
☐ **269**	**Non-Syndromic Congenital Muscular Dystrophy (CMD) Evaluation** (FKRP, LAMA2, COL6A1, COL6A2, COL6A3)	B	2-4 mL	L
☐ **293**	**Collagen VI-Related CMD Evaluation** (COL6A1, COL6A2, COL6A3)	B	2-4 mL	L
☐ 216	FKRP (for CMD) DNA Sequencing Test	B	2-4 mL	L
☐ 217	LAMA2 DNA Sequencing Test	B	2-4 mL	L
☐ 218	POMT1 DNA Sequencing Test	B	2-4 mL	L
☐ 219	POMT2 DNA Sequencing Test	B	2-4 mL	L
☐ 220	POMGNT1 DNA Sequencing Test	B	2-4 mL	L
☐ 232	FCMD DNA Sequencing Test	B	2-4 mL	L
☐ 201	COL6A1 DNA Sequencing Test	B	2-4 mL	L
☐ 202	COL6A2 DNA Sequencing Test	B	2-4 mL	L
☐ 203	COL6A3 DNA Sequencing Test	B	2-4 mL	L
☐ **147**	**Complete Myotonia Evaluation** (DM1, DM2, CLCN1, SCN4A)	B	10 mL	L
☐ **207**	**Early-Onset Myotonia Evaluation** (DM1, CLCN1, SCN4A)	B	10 mL	L
☐ 108	DM1 DNA Test	B	10 mL	L
☐ 110	DM2 DNA Test			
☐ 128	CLCN1 DNA Test			
☐ 146	SCN4A DNA Test			
☐ **494**	**Neuromyotonia Evaluation** CASPR2, VGKC Antibody Tests	S	2 mL	R
☐ **669**	**Emery-Dreifuss Muscular Dystrophy Evaluation** (EMD, FHL1, LMNA/C)	B	10 mL	L
☐ 567	EMD DNA Sequencing Test	B	10 mL	L
☐ 574	FHL1 DNA Sequencing Test	B	10 mL	L
☐ **603**	**Complete Limb Girdle Muscular Dystrophy Evaluation** (CAPN3, CAV3, Dysferlin Sequencing, FKRP, LMNA, SGCA, B, G, D, MYOT, SGCA Deletion, SGCB Sequencing, SGCG Sequencing/Deletion, CAPN3 Deletion)	B	20 mL	L
☐ **587**	**Complete Sarcoglycans Evaluation** SGCA, B, D, G Sequencing, SGCA Deletion, SGCG Deletion	B	10 mL	L
☐ **585**	**CAPN3 Evaluation** (includes CAPN3 Sequencing, CAPN3 Deletion)	B	10 mL	L
☐ 568	SGCA, B, D, G DNA Sequencing Test	B	10 mL	L
Individual Limb Girdle Muscular Dystrophy Tests:		B	10 mL	L
☐ 562 FKRP	☐ 563 CAPN3	☐ 565 LMNA		
☐ 566 CAV3	☐ 564 SGCA	☐ 051 SGCB		
☐ 052 SGCD	☐ 053 SGCG			
☐ 581 MYOT DNA Sequencing Test				
☐ 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 DNA Test	B	20 mL	L
☐ 300	OPMD DNA Test	B	10 mL	L
☐ **490**	**Optic Atrophy Evaluation** (OPA1)	B	20 mL	L
☐ 600	Peroxisomal Disorders Test (VLCFA, Phytanic acid)		Please Call	
☐ **501**	**Myoglobinuria Test Evaluation** (LDH, PGM, PGK, Glycogen, Ph, PhK, PFK, MAD, CPT2)	M	250 mg	C
☐ **502**	**Glycogen Storage Myopathy 'A' Evaluation** (Glycogen, Acid and neutral maltase, Debrancher)	M	200 mg	C
☐ **504**	**Lipid Storage Myopathy Evaluation** (Carnitine free and total)	M	100 mg	C

Test Code		Pref. Spec.	Min. Vol.	Tube Type
Neuro-Oncology				
☐ **648**	**Neurofibromatosis Type 1 (NF1) Evaluation** (NF1 Sequencing, NF1 Deletion)	B	10 mL	L
☐ **645**	**Neurofibromatosis Type 2 (NF2) Evaluation** (NF2 Sequencing, NF2 Duplication/Deletion)	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				
☐ **467**	**NeoComplete Paraneoplastic Evaluation with Recombx® (Reflexive)** Testing is performed in this order: Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, VGCC, VGKC, Amphiphysin, nAChR, NR1, GAD65, LGI1, CASPR2. Test will reflex to GAD65 if all other antibodies are negative.	S	2 mL	R
☐ **438**	**NeoCerebellar Degeneration Paraneoplastic Evaluation with Recombx®** (Hu, Yo, Zic4, CV2, MaTa, Ri, Amphiphysin, GAD65)	S	2 mL	R
☐ **447**	**NeoEncephalitis Paraneoplastic Evaluation with Recombx®** (Hu, CV2, MaTa, VGKC, Amphiphysin, NR1, GAD65, LGI1, CASPR2)	S	2 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: ☐ 118 CAR ☐ 123 CV2 ☐ 120 Hu ☐ 122 MaTa ☐ 115 Ri ☐ 125 Yo ☐ 127 Zic4		S	2 mL	R
☐ 449	LGI1 Antibody Test	S	2 mL	R
☐ 499	CASPR2 Antibody Test	S	2 mL	R
☐ 419	NMDA (NR1) Antibody Test	S	2 mL	R
☐ 422	GAD65 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

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
☐ **346**	**Motor Neuropathy Evaluation** (Co-GM1 Quattro®, MAG 'Dual Antigen'®, NS6S)	S	2 mL	R
☐ **356**	**Multifocal Motor Neuropathy Evaluation** (Co-GM1 Quattro®, PMP22 Duplication/Deletion, NS6S)	S B	2 mL 10 mL	R L
☐ **234**	**Small Fiber Painful Axonal Neuropathy Evaluation** (Hu, Sulfatide, TTR)	S B	2 mL 5 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
☐ 344	NS6S 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				
☐ **404**	**Complete CMT Evaluation** (Includes all individual CMT DNA tests, see below)	B	15 mL	L
☐ **414**	**Dominant CMT Evaluation** (MFN2, Cx32, Cx32 Deletion, MPZ, EGR2, NFL, PMP22 Sequencing, LITAF/SIMPLE, PMP22 Duplication/Deletion, RAB7, GARS, HSPB1)	B	15 mL	L
☐ **407**	**Partial CMT – Demyelinating Only** (Cx32, Cx32 Deletion, MPZ, EGR2, PMP22 Sequencing, PMP22 Duplication/Deletion, GDAP1, PRX, LITAF/SIMPLE, SH3TC2)	B	15 mL	L
☐ **413**	**Partial CMT – Axonal Only** (Cx32, Cx32 Deletion, MPZ, NFL, GDAP1, MFN2, RAB7, GARS, HSPB1, LMNA)	B	15 mL	L
☐ **409**	**Partial CMT – Recessive Only** (PRX, EGR2, GDAP1, SH3TC2, FIG4, LMNA)	B	15 mL	L
☐ **243**	**Complete HNPP Evaluation** (PMP22 Sequencing, PMP22 Duplication/Deletion)	B	20 mL	L
☐ **286**	**Complete Dejerine-Sottas Neuropathy Evaluation** (MPZ, EGR2, PMP22 Sequencing, PRX)	B	20 mL	L

Test Code		Pref. Spec.	Min. Vol.	Tube Type
☐ **347**	**Chronic Demyelinative Neuropathy Evaluation** (MAG 'Dual Antigen'®, GD1b, PMP22 Duplication/Deletion, Cx32, Cx32 Deletion)	2 B	2 mL 15 mL	R L
☐ **245**	**Congenital Hypomyelination Evaluation** (MPZ, EGR2)	B	15 mL	L
☐ **296**	**Entrapment Neuropathy Evaluation** (PMP22 Sequencing, PMP22 Duplication/Deletion, TTR)	B	15 mL	L
☐ **235**	**Amyloidosis Evaluation** (TTR)	B	10 mL	L
Individual CMT DNA Tests: ☐ 221 GDAP1 (CMT2K, 4A) ☐ 222 LITAF/SIMPLE (CMT1C) ☐ 223 MFN2 (CMT2A2) ☐ 239 Periaxin (CMT4F) ☐ 247 PMP22 Seq. ☐ 248 EGR2 (CMT1D) ☐ 249 NFL (CMT2E, 1F) ☐ 131 PMP22 Dup./Del. (CMT1A) ☐ 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)		B	10 mL	L
Thrombosis				
☐ **098**	**THROMBX® Evaluation Profile I** (Factor V, ATIII function, Protein C function, Protein S function, Anticardiolipin: IgG, IgM, IgA screen) Serum and citrated plasma must be sent frozen. Whole blood should be sent at room temperature	B S P	10 mL 2 mL 1 mL	L R B
☐ **099**	**THROMBX® Evaluation Profile II** (Factor V, ATIII function, Protein C antigen, Protein S antigen, Protein C/Factor VII ratio, Protein S/Factor VII ratio, Anticardiolipin: IgG, IgM, IgA screen) Serum and citrated plasma must be sent frozen. Whole blood should be sent at room temperature	B S P	10 mL 2 mL 1 mL	L R B
☐ 090	THROMBOGENE V® Test (Factor V)	B	10 mL	L

Specimen Type

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

Tube Type

P – Polypropylene CSF Transfer Tube
G – Green
L – Lavender
B – Blue
R – Red
C – Cryovial

The following tests are not performed at Athena Diagnostics: 630, 514.
For tests 098 and 099 Factor V is performed at Athena Diagnostics.

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 should also be indicated on the test requisition.

Athena Diagnostics Client Service Representatives are available from 8:30 a.m. to 6:30 p.m. Eastern Time (US).

Customers in the US and Canada please call toll-free

866-AthenaDx (866-284-3623)

(Non-US customers please call 508-756-2886 or fax 508-753-5601.)

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ADX146SG-5/12AK-REV33

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