For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

MNG LABORATORIES
A LabCorp Company

Patient and Specimen Information Form

5424 Glenridge Drive NE | Atlanta, GA 30342 USA | phone: 844.664.8378 | fax: 678.225.0212 | mnglabs.com

Patient and Specimen Information

Patient Last Name	Patient First Name
Patient ID #	Date of Birth [MM/DD/YYYY]
Diagnosis/ICD-10	Collection Date [MM/DD/YYYY]

Gender ☐ Male ☐ Female

Specimen Type
☐ Whole Blood ☐ Buccal Swab ☐ CSF ☐ Urine ☐ Fibroblasts ☐ Plasma/ Serum ☐ Muscle ☐ DNA Tissue:_____

Please complete and include clinical information form, or attach clinical notes

Referring Physician Information

Physician Name	NPI # or equivalent *(Required)*
Facility / Organization	Signature
Facility Address City, State, Zip Code ☐ Same as billing	
Report Delivery ☐ Fax ☐ Email	Phone

Billing Information *(REQUIRED)*

Self-Pay? ☐ Yes If yes, **MUST** include payer contact name & details below. Payment must be received in full prior to testing.

Facility	Contact Name
Billing Address	
City, State, Zip Code	
Phone Fax	Email

Results

Authorized Recipient Name	Authorized Recipient Name
Facility Phone	Facility Phone
☐ Fax	☐ Fax
☐ Email	☐ Email

Testing Checklist

All of the following are encouraged to be included with test orders (please check the following):

- ☐ All specimens that will be analyzed must be received - please note if samples will ship separately
- ☐ Clinical Information Form completed
- ☐ Informed Consent for Genetic Testing completed and signed

MNG LABORATORIES
A LabCorp Company

Neurochemistry & Metabolic Test Request Form

5424 Glenridge Drive NE | Atlanta, GA 30342 USA | phone: 844.664.8378 | fax: 678.225.0212 | mnglabs.com

Patient Name _____ DOB _____

Metabolic

CSF

- ☐ (MET01) Amino Acids†
- ☐ (MET07) Lactate
- ☐ (MET11) Pyruvate*
- ☐ (NC01) 5-Methyltetrahydrofolate
- ☐ (NC02) Neopterin [*Marker for CNS Immune System Stimulation*]
- ☐ (NC03) Neopterin/Tetrahydrobiopterin
- ☐ (NC04) Neurotransmitter Metabolites (5HIAA, HVA, 3OMD) [*Includes Biomarkers for Pyridoxine Responsive Seizures*]
- ☐ (NC05) Pyridoxal 5'-phosphate [*Pyridox[am]ine Phosphateoxidase Deficiency + CNS Pyridoxal 5'-phosphate Deficiency*]
- ☐ (NC06) Succinyladenosine [*Adenylosuccinate Lyase Deficiency*]
- ☐ (NC07) Sialic Acid [*Disorders with Hypomyelination of Unknown Etiology/ Sialic Acid Storage Disorders*]
- ☐ (NC08) Alpha-Aminoadipic Semialdehyde [*Pyridoxine-Responsive Seizures*]
- ☐ (NC10) Glucose [*Glucose Transporter Deficiency*]
- ☐ (NC15) Sepiapterin & Dihydrobiopterin

Blood & Muscle

- ☐ (MET02) Amino Acids (Plasma)†
- ☐ (MET04) Coenzyme Q10 Level (Leukocytes)
- ☐ (MET05) Coenzyme Q10 Level (Muscle)
- ☐ (MET08) Lactate (Plasma)
- ☐ (MET10) Pyruvate* (Blood)
- ☐ (MET12) Thymidine/Deoxyuridine Analytes (Plasma)
- ☐ (MET23) Creatine & Guanidinoacetate (Plasma)
- ☐ (MET24) Glucose (Plasma)
- ☐ (MET29) 3-O-Methyldopa (Plasma) [*Specific Marker for Aromatic L-Amino Acid Decarboxylase Deficiency]*

Urine

- ☐ (MET03) Amino Acids†
- ☐ (MET19) Creatine & Guanidinoacetate
- ☐ (MET20) Alpha Aminoadipic Semialdehyde [*Urine; for Pyridoxine-Responsive Seizures]*

Enzymology

Blood

- ☐ (ENZ01) Aromatic L-amino Acid Decarboxylase Enzyme Analysis (Plasma) - *STAT Not Available*
- ☐ (ENZ06) Thymidine Phosphorylase Enzyme Analysis (Blood) - *STAT Not Available*

† Denotes testing performed at LabCorp, Burlington, NC - *STAT Not Available*

*Denotes testing requires deproteinization

MNG LABORATORIES
A LabCorp Company

Clinical Information Form

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Patient Name _____ DOB _____

Clinical (Check All That Apply)

Eye ☐ Retinitis Pigmentosa ☐ Optic Atrophy ☐ Other

Hearing ☐ Sensorineural ☐ Stickler ☐ Usher

Neuronal Migration ☐ Meckel ☐ Joubert ☐ Other

☐ Stroke

Cognitive/Neurobehavioral ☐ Intellectual Disability (ID) ☐ Syndromic ID ☐ Nonsyndromic ID ☐ Autism ☐ Dementia

Movement Disorders ☐ Ataxia ☐ Episodic Ataxia ☐ Dystonia ☐ Chorea/Athetosis ☐ Parkinson Disease ☐ L-Dopa Response

Epilepsy ☐ Myoclonic ☐ Other ☐ Absence ☐ Tonic Clonic ☐ Epileptic Encephalopathy

Spasticity ☐ Spastic Paraplegia ☐ Other ☐ Spastic Quadriplegia

Connective Tissue & Bone ☐ Ehlers Danlos ☐ Marfan ☐ Aneurysms ☐ Other

Neuromuscular ☐ Distal ☐ Proximal ☐ Muscle Atrophy ☐ Contractures ☐ Malignant Hyperthermia ☐ Arthrogryposis ☐ Rhabdomyolysis ☐ Periodic Paralysis ☐ Statin Use ☐ Myasthenia

Nerve/Anterior Horn Cell ☐ Neurofibromas ☐ Charcot-Marie-Tooth ☐ Sensory ☐ Autonomic ☐ Pain ☐ Motor ☐ Nerve Conduction ☐ Other

Cardiomyopathy ☐ Dilated ☐ Hypertrophic ☐ Noncompaction

Arrhythmias ☐ Ventricular Tachycardia ☐ Brugada ☐ Long or Short QT ☐ Conduction Defect

Congenital Heart Defects ☐ Heterotaxy ☐ Other

Endocrine ☐ Hypothyroidism ☐ Other ☐ Diabetes Mellitus

Imaging (Check All That Apply)

Brain MRI

☐ Leigh Disease
☐ Basal Ganglia Calcification
☐ Stroke
☐ Cerebellar Atrophy
☐ Abnormal Myelin (describe)

EEG (Describe Findings)

EMG/NVC (Describe Findings)

Laboratory

Metabolic (Describe Findings)

CPK Maximum _____
Minimum _____

Genetic (Describe Findings)

☐ Chromosomal Microarray
☐ Deletion/Insertion Testing
☐ Other (comment)

Family History

Ethnicity (please check)

☐ Caucasian ☐ Sephardic Jewish ☐ African American (or Black) ☐ Asian
☐ Hispanic ☐ Ashkenazi Jewish ☐ Native American (or American Indian) ☐ Other: _____

Affected Maternal Lineage	Affected Paternal Lineage	Siblings
Relationship to Proband	Relationship to Proband	Number (specify gender)
Symptoms	Symptoms	Healthy/Affected

Additional Comments

MNG LABORATORIES
A LabCorp Company

STAT Test Request Form

5424 Glenridge Drive NE | Atlanta, GA 30342 USA | phone: 844.664.8378 | fax: 678.225.0212 | mnglabs.com

Patient Name _____ DOB _____

STAT Testing - Expedite Your Results

IMPORTANT: To request STAT Testing, STAT Testing Form must be ***completed, signed and submitted*** with test request form. Failure to do so will delay your order.

For an additional fee, the following tests are available for STAT Testing:

Neurochemistry (NC) & Metabolic (MET) Tests 7 day TAT	Molecular (MOL) Tests 2 week TAT	Next-Generation Sequencing (NGS) Panels 2 week TAT

NOTE: MNG Laboratories will ensure any STAT orders meet the stated deadline, or the STAT fee will be waived.

Patient and Specimen Information

Patient Last Name	Patient First Name
Patient ID #	Date of Birth [MM/DD/YYYY]

Test Code

IMPORTANT: Enzymology, familial variants, and RNA tests NOT available as STAT

Test Code: _____	**Test Code:** _____	**Test Code:** _____
Test Code: _____	**Test Code:** _____	**Test Code:** _____
Test Code: _____	**Test Code:** _____	**Test Code:** _____
Test Code: _____	**Test Code:** _____	**Test Code:** _____

Billing Information *(REQUIRED)*

Self-Pay? ☐ Yes If yes, **MUST** include payer contact name & details below. Payment must be received in full prior to testing.

Facility		Contact Name
Billing Address		
City, State, Zip Code		
Phone	Fax	Email

I HEREBY ACKNOWLEDGE *(check all & sign below)*:

☐ I acknowledge that the responsibile billing party listed above will pay for the additional costs associated with ordering a STAT Test. I understand that failure to submit payment for STAT Testing will delay my order.

☐ I consent that all requested STAT Tests listed above are either Neurochemistry tests, Metabolic tests, Molecular Tests or Next-Generation Sequencing Panels. I understand that all other tests are not available for STAT Testing and will not be ran as a STAT Test if requested.

Signature of Responsible Billing Party (*required*): _____