

Commercial Insurance Test Requisition (July 2010)

***Indicates required information**

Medicare Patients – Please use the Athena Diagnostics Medicare Test Requisition Form. For a copy, please call Client Services or visit our website AthenaDiagnostics.com/medicare.

Medicaid/Patients Requesting Financial Assistance – Patients who meet certain income guidelines may qualify for a discount off the price of testing. Please complete the patient identification information and Athena will contact the patient directly to initiate the application process and collect pre-payment.

PATIENT

Commercially Insured Patient Information

Complete this requisition for all patients with commercial insurance. Patients with a commercial insurance plan for which Athena is a contracted provider are subject to any co-insurance and deductible of their plan. Patients with a commercial insurance plan for which Athena is not a contracted provider but who have diagnostic testing (including genetic testing where applicable) as a defined benefit on their insurance plan may, in certain States, participate in Athena's Patient Protection Plan. Under this plan, the patient's out-of-pocket exposure will be no more than 20% of billed charges or \$500, whichever is less. Athena will bill the patient's insurance for the total price of the test and work on his or her behalf to file all appropriate justifications and/or appeals to maximize the amount paid by the insurance when applicable. Upon receipt of the patient specimen, Athena will contact the patient to gather any missing insurance information and explain the Patient Protection Plan, if the patient does not choose to participate in the Patient Protection Plan, Athena will still bill their insurance company. However, if the insurance company does not pay the full amount, the patient may be responsible for the balance.

1. Commercial insurance does not include certain Medicare, Medicare HMO, Medicare PPO, Medicaid, or Tricare/Champus, programs for which there is a specific government-mandated billing process. Patients should verify coverage with their individual provider prior to testing. 2. Due to State laws, the Patient Protection Plan is not available in all States.

Patient Identification

Patient Name* _____
First Last

Patient ID # (if available) _____

S.S. # _____ Sex: M F Unknown

DOB* _____ Age* _____

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 my health plan on **my behalf**² 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 if I choose not to participate in the Patient Protection Plan² I may be responsible for all charges not covered by my insurance carrier within sixty (60) days of claim submission. I authorize and direct that benefits under this claim be paid directly to Athena Diagnostics, and I agree to remit to Athena within thirty (30) days 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.

2. Due to State laws, the Patient Protection Plan is not available in all States. 3. Athena Diagnostics and or designee may perform this appeal on my behalf, but is not obligated to do so.

Patient Signature* _____

Date _____

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

Member ID #* _____

Group ID #* _____

Insurance Co. Name* _____

Address* _____

City* _____ State* _____ Zip* _____

Phone _____

PHYSICIAN

Physician/Laboratory Contact Information

NOTE: Two forms of patient ID must be listed on EACH specimen tube.

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-9 Code (Required): _____

For BAbs/NAbs Testing, please provide IFN-β start date: _____

Indications for Testing (Check One)*

Diagnostic (symptomatic) Clinical Study Prenatal
 Predictive (asymptomatic) Carrier Other Research

Testing Authorization and ICD-9 Code: I warrant that this test is either: 1) for the purpose of diagnosing or detecting an existing disease, illness, impairment, symptom or disorder, or 2) that 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* _____

Required Physician Information

NPI #* _____ UPIN #* _____

Name* _____
First Last

Address _____

City _____ State _____ Zip _____

Phone* _____ Fax _____

Email* _____

Additional Authorized Result Report Recipient

Name _____
First Last

UPIN # or CLIA # _____

Address _____
(P.O. Box not acceptable)

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Type of Specimen Whole Blood Serum CSF Buccal Swabs Muscle Plasma CVS: Direct CVS: Cultured
 Amniotic Fluid: Direct Amniotic Fluid: Cultured **Date Collected*** _____

NOTE: Two forms of patient ID must be listed on EACH specimen tube.

**For Athena's Specimen Collection Service*,
 Please Fax this Test Requisition to Access Athena™ at 866-223-1247**

*Specimen collection service will work with the patient to obtain phlebotomy services through either a home draw or other laboratory.

Athena Diagnostics Testing Services (July 2010)

Not all available tests are listed here. Please see our catalog or website for complete offering, as well as CPT codes for each test.

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

Test Code	Preferred Specimen	Minimum Volume	Tube Type
Dementia			
<input type="checkbox"/> 178 ADmark® Alzheimer's Evaluation* (ApoE, Phospho-Tau, Total-Tau, Aβ42) (Symptomatic for Dementia)	C, B	2ml, 10ml	P, L
<input type="checkbox"/> 179 ADmark® Early-Onset Alzheimer's Evaluation* (PS-1, APP Sequencing/Duplication, PS-2)	B	10ml	L
<input type="checkbox"/> 109 ADmark® ApoE Genotype Analysis & Interpretation* (Symptomatic for Dementia)	B	10ml	L
<input type="checkbox"/> 177 ADmark® Phospho-Tau/Total-Tau/Aβ42 CSF Analysis & Interpretation* (Symptomatic) (must arrive in Polypropylene CSF transfer tube)	C	2ml	P
<input type="checkbox"/> 167 ADmark® PS-1 DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 168 ADmark® APP DNA Sequencing/Duplication Test*	B	10ml	L
<input type="checkbox"/> 169 ADmark® PS-2 DNA Sequencing Test*	B	10ml	L
Developmental Disorders			
<input type="checkbox"/> 743 Autism Spectrum Disorders Evaluation* (SHANK3, CNTNAP2)	B	10ml	L
<input type="checkbox"/> 741 CNTNAP2 DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 742 SHANK3 DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 104 Fragile X (FMR1) DNA Test*	B	20ml	L
<input type="checkbox"/> 753 Smith-Magenis (RAI1) Reflexive Profile* Testing is performed in this order: 1. RAI1 Deletion; 2. RAI1 Sequencing	B	5ml	L
<input type="checkbox"/> 751 Smith-Magenis (RAI1) Deletion Test*	B	5ml	L
<input type="checkbox"/> 752 Smith-Magenis (RAI1) Sequencing Test*	B	5ml	L
<input type="checkbox"/> 737 Smith-Lemli-Opitz Syndrome (DHCR7) DNA Test*	B	5ml	L
<input type="checkbox"/> 744 PTEN DNA Sequencing Test*	B	5ml	L
<input type="checkbox"/> 729 Cohen Syndrome (COH1) DNA Sequencing Test*	B	5ml	L
<input type="checkbox"/> 153 Complete Rett Syndrome Evaluation* (MECP2 Sequencing, MECP2 Duplication/Deletion)	B	10ml	L
<input type="checkbox"/> 142 Rett Syndrome (MECP2) DNA Sequencing Test	B	10ml	L
<input type="checkbox"/> 148 Rett Syndrome (MECP2) Duplication/Deletion Analysis*	B	10ml	L
<input type="checkbox"/> 149 CDKL5 DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 141 ARX DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 706 Chromosome Analysis with Fragile X DNA Test*	B	20ml, 20ml	L, G
<input type="checkbox"/> 707 Chromosome Analysis – High Resolution*	B	30ml	G
<input type="checkbox"/> 630 Norrie Disease DNA Test*	B	20ml	L
<input type="checkbox"/> 782 60K Chromosomal Microarray Analysis*	Adult: B	10ml, 10ml	L, G
<input type="checkbox"/> 783 180K Chromosomal Microarray Analysis*	Child: B Infant: B	8ml, 8ml 4ml, 4ml	L, G L, G
Indication for Study (MUST check one or more below):			
<input type="checkbox"/> Developmental Delay: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Mental Retardation: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Autistic Spectrum <input type="checkbox"/> Failure to Thrive <input type="checkbox"/> Trisomy 13 <input type="checkbox"/> Multiple Congenital Anomalies <input type="checkbox"/> Infertility <input type="checkbox"/> Trisomy 18 <input type="checkbox"/> Dysmorphic Features <input type="checkbox"/> Fetal Demise <input type="checkbox"/> Trisomy 21 <input type="checkbox"/> Klinefelter Syndrome <input type="checkbox"/> Turner Syndrome <input type="checkbox"/> Testicular Failure <input type="checkbox"/> Multiple Miscarriages (# _____) <input type="checkbox"/> Ambiguous Genitalia <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____ <input type="checkbox"/> 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 Institute 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.			
Epilepsy			
<input type="checkbox"/> 556 Complete Tuberous Sclerosis Evaluation* (TSC1 Seq., TSC1 Del., TSC2 Seq., TSC2 Del.)	B	20ml	L
<input type="checkbox"/> 521 TSC1 DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 508 TSC1 DNA Deletion Test*	B	10ml	L
<input type="checkbox"/> 522 TSC2 DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 524 TSC2 DNA Deletion Test*	B	10ml	L
<input type="checkbox"/> 523 TSC Familial Mutation Evaluation*	B	10ml	L
Proband Accession # _____ Relationship _____			
<input type="checkbox"/> 549 Alexander Disease (GFAP) DNA Sequencing Test	B	10ml	L

Test Code	Preferred Specimen	Minimum Volume	Tube Type
<input type="checkbox"/> 441 SLC2A1 (GLUT1-DS) DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 418 Myoclonus Epilepsy Evaluation* (EPM1, EPM2A, EPM2B, MERRF, EFHC1)	B	20ml	L
<input type="checkbox"/> 507 Female Febrile Seizures Evaluation* (PCDH19 Seq., SCN1A Seq., SCN1A Del., SCN1B Seq., GABRG2 Seq.)	B	10ml	L
<input type="checkbox"/> 548 Febrile Seizures Evaluation* (SCN1A Seq., SCN1A Del., SCN1B Seq., GABRG2 Seq.)	B	10ml	L
<input type="checkbox"/> 573 SCN1A Complete Evaluation* (SCN1A Sequencing, SCN1A Deletion)	B	10ml	L
<input type="checkbox"/> 509 PCDH19 (EFMR) DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 535 SCN1A DNA Sequencing Test*			
<input type="checkbox"/> 537 SCN1A Deletion Test*			
<input type="checkbox"/> 538 SCN1B DNA Sequencing Test*			
<input type="checkbox"/> 544 GABRG2 DNA Sequencing Test			
<input type="checkbox"/> 415 Lafora Disease Evaluation* (EPM2A, EPM2B)	B	20ml	L
<input type="checkbox"/> 411 EPM2A DNA Test*	B	10ml	L
<input type="checkbox"/> 412 EPM2B DNA Test*			
<input type="checkbox"/> 410 EPM1 (Unverricht-Lundborg) DNA Test*			
<input type="checkbox"/> 545 KCNQ2 (BFNC) DNA Sequencing Test*			
<input type="checkbox"/> 417 EFHC1 (JME) DNA Sequencing Test*			
<input type="checkbox"/> 572 KCNJ10 DNA Sequencing Test*			
<input type="checkbox"/> 547 ADNFLE Evaluation* (CHRNA4, CHRNB2)	B	10ml	L
<input type="checkbox"/> 546 CHRNA4 DNA Sequencing Test*	B	10ml	L
NOTE: Pediatric minimum for all Epilepsy tests is 2ml.			
Family Testing			
<input type="checkbox"/> 185 Familial DNA Sequence Evaluation*	B	10ml	L
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 Test Code 523.			
Proband Accession # _____ Relationship _____			
Hearing Loss			
<input type="checkbox"/> 329 Connexin Related Deafness Evaluation* (Connexin 26, Connexin 30)	B	10ml	L
<input type="checkbox"/> 321 Connexin 26 DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 319 Connexin 30 DNA Deletion Test*			
<input type="checkbox"/> 327 OtoDx™ Aminoglycoside Hypersensitivity Test*	B	20ml	L
Migraine			
<input type="checkbox"/> 190 Hemiplegic Migraine Evaluation* (CACNA1A, ATP1A2, SCN1A)	B	10ml	L
<input type="checkbox"/> 187 FHM1 DNA Test (CACNA1A)*	B	10ml	L
<input type="checkbox"/> 188 FHM2 DNA Test (ATP1A2)*			
<input type="checkbox"/> 189 FHM3 DNA Test (SCN1A)*			
Motor Neuron Diseases			
<input type="checkbox"/> 650 Complete Hereditary Spastic Paraplegia Evaluation* (Includes all individual HSP DNA tests, see below.)	B	10ml	L
<input type="checkbox"/> 651 Autosomal Dominant Hereditary Spastic Paraplegia Evaluation* (SPG3A, SPG4, SPG4 Del., SPG6, SPG8, SPG17, SPG31)	B	10ml	L
<input type="checkbox"/> 652 Autosomal Recessive Hereditary Spastic Paraplegia Evaluation* (SPG7, SPG11)	B	10ml	L
Individual HSP DNA Tests:			
<input type="checkbox"/> 530 Spastin (SPG4)*	<input type="checkbox"/> 532 NIPA1 (SPG6)*		
<input type="checkbox"/> 531 Atlastin (SPG3A)*	<input type="checkbox"/> 533 Strumpellin (SPG8)*		
<input type="checkbox"/> 529 REEP1 (SPG31)*	<input type="checkbox"/> 632 Paraplegin (SPG7)*		
<input type="checkbox"/> 534 Spastin (SPG4 Del.)*	<input type="checkbox"/> 633 Spatacsin (SPG11)*		
	<input type="checkbox"/> 631 BSCL2 (SPG17)*		
<input type="checkbox"/> 215 Complete SMA Evaluation (Reflexive)*	B	4ml	L
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), XLSMA			
<input type="checkbox"/> 214 SMA Plus (Reflexive)*	B	4-10ml	L
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			
<input type="checkbox"/> 111D Spinal Muscular Atrophy – Diagnostic* (Including SMN2 Copy Number)	B	10ml	L
<input type="checkbox"/> 211 Spinal Muscular Atrophy – SMN1 DNA Sequencing Test*	B	4ml	L

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

Test Code		Preferred Specimen	Minimum Volume	Tube Type
<input type="checkbox"/> 212	Spinal Muscular Atrophy with Respiratory Distress (SMARD) IGHMBP2 DNA Sequencing Test*	B	4ml	L
<input type="checkbox"/> 213	X-Linked Spinal Muscular Atrophy (XLSMA) UBE1 DNA Sequencing Test (Exon 15 only)*	B	4ml	L
<input type="checkbox"/> 448	SMA Carrier Plus (Reflexive)* Carrier testing performed in this order: 1. SMN1 Deletion; 2. SMN1 Sequencing	B	4-10ml	L
<input type="checkbox"/> 444	Spinal Muscular Atrophy – Carrier* SMN1 Deletion Test	B	4ml	L
<input type="checkbox"/> 117	Kennedy Disease (SBMA) DNA Test*	B	10ml	L
<input type="checkbox"/> 723	Complete ALS Evaluation* (SOD1, FUS, TARDBP, ANG, FIG4)	B	10ml	L
<input type="checkbox"/> 620	SOD1 DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 619	FUS DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 621	TARDBP DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 622	ANG DNA Sequencing Test*	B	10ml	L
Movement Disorders				
<input type="checkbox"/> 695	Complete Ataxia Evaluation (Includes all individual Ataxia genes, see below.)	B	20ml	L
<input type="checkbox"/> 694	Autosomal Dominant Ataxia Evaluation (SCA1,2,3,5,6,7,8,10,13,14,17, DRPLA)	B	20ml	L
<input type="checkbox"/> 693	Autosomal Recessive Ataxia Evaluation* (APTX, SETX, SIL1, POLG1, TTPA, FRDA Seq., FRDA Expansion)	B	20ml	L
Individual Ataxia DNA Tests:		B	10ml	L
<input type="checkbox"/> 371	SCA1	<input type="checkbox"/> 672	SCA2	
<input type="checkbox"/> 105	SCA3	<input type="checkbox"/> 675	SCA5	
<input type="checkbox"/> 373	SCA6*	<input type="checkbox"/> 677	SCA7	
<input type="checkbox"/> 384	SCA8	<input type="checkbox"/> 387	SCA10	
<input type="checkbox"/> 284	SCA13	<input type="checkbox"/> 593	SCA14	
<input type="checkbox"/> 388	SCA17	<input type="checkbox"/> 493	APTX	
<input type="checkbox"/> 401	DRPLA	<input type="checkbox"/> 383	POLG1 (MIRAS)	
<input type="checkbox"/> 594	SETX	<input type="checkbox"/> 282	SIL1 (MSS)	
<input type="checkbox"/> 283	TTPA (AVED)	<input type="checkbox"/> 348	FRDA DNA Seq.	
<input type="checkbox"/> 119	FRDA Expansion			
<input type="checkbox"/> 349	Friedreich's Ataxia Profile (FRDA Seq., FRDA Expansion)	B	10ml	L
<input type="checkbox"/> 353	Complete Ataxia-Telangiectasia (ATM) Evaluation* (ATM Sequencing, ATM Duplication/Deletion)	B	10ml	L
<input type="checkbox"/> 351	Ataxia-Telangiectasia (ATM) DNA Sequencing Analysis*	B	10ml	L
<input type="checkbox"/> 352	Ataxia-Telangiectasia (ATM) DNA Dup./Del. Analysis*	B	10ml	L
<input type="checkbox"/> 402	Chorea Differential Evaluation* (DRPLA, HD)	B	20ml	L
<input type="checkbox"/> 116	Huntington's Disease DNA Test*	B	10ml	L
<input type="checkbox"/> 639	Primary Dystonia Evaluation* (DYT1, THAP1)	B	10ml	L
<input type="checkbox"/> 626	Dystonia (DYT1) DNA Test*	B	20ml	L
<input type="checkbox"/> 618	THAP1 (DYT6) DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 629	Complete Dopa-Responsive Dystonia (DYT5) Evaluation* (GCH1 Seq., GCH1 Del., TH Seq.)	B	10ml	L
<input type="checkbox"/> 637	GCH1 DNA Sequencing Test (DYT5)*	B	10ml	L
<input type="checkbox"/> 638	GCH1 Del. Analysis (DYT5)*	B	10ml	L
<input type="checkbox"/> 634	TH DNA Sequencing Test (DYT5)*	B	10ml	L
<input type="checkbox"/> 624	SGCE DNA Sequencing Test (DYT11)*	B	10ml	L
<input type="checkbox"/> 627	SGCE Del. Analysis (DYT11)*	B	10ml	L
<input type="checkbox"/> 617	MR-1 (PNKD) DNA Sequencing Test	B	10ml	L
<input type="checkbox"/> 106	FXTAS DNA Test*	B	20ml	L
<input type="checkbox"/> 555	Complete Parkinsonism Evaluation* (Parkin, PINK1, LRRK2)	B	20ml	L
<input type="checkbox"/> 550	Autosomal Recessive Parkinsonism Evaluation* (Parkin, PINK1)	B	20ml	L
<input type="checkbox"/> 540	Parkin DNA Test*	B	20ml	L
<input type="checkbox"/> 542	PINK1 DNA Sequencing Test*			
<input type="checkbox"/> 543	LRRK2 DNA Test			
Multiple Sclerosis				
<input type="checkbox"/> 194	BAbScreen®/NAbFeron® (IFN-β) Antibody Test (Binding Antibody positive confirmed by NAbFeron® Test)	S	2ml	R
<input type="checkbox"/> 112	NAbFeron® (IFN-β) Neutralizing Antibody Test	S	2ml	R
<input type="checkbox"/> 197	Tysabri® (Natalizumab) Antibody Test <i>(must arrive on cold pack)</i>	S	2ml	R
<input type="checkbox"/> 193	Neuromyelitis Optica (NMO) Autoantibody Test*	S	2ml	R

Test Code		Preferred Specimen	Minimum Volume	Tube Type
Neuromuscular Disorders				
<input type="checkbox"/> 482	MuSK Quantitative Titers Antibody Test	S	2ml	R
<input type="checkbox"/> 483	AChR/MuSK Reflexive Antibody Test (Now with MuSK quantitative titers levels)	S	2ml	R
<input type="checkbox"/> 506	Male Muscular Dystrophy Reflexive Profile 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 Del./Dup.; 2. DMD Seq.; 3. Limb Girdle Muscular Dystrophy Evaluation.	B	20ml	L
<input type="checkbox"/> 181	Complete DMD Evaluation – Males*	B	20ml	L
<input type="checkbox"/> 182	Complete DMD Evaluation – Females*	B	20ml	L
<input type="checkbox"/> 101	Partial DMD Deletion/Duplication only – Males*	B	20ml	L
<input type="checkbox"/> 103	Partial DMD Deletion/Duplication only – Females*	B	20ml	L
<input type="checkbox"/> 183	Partial DMD DNA Sequencing Only*	B	20ml	L
<input type="checkbox"/> 100	Dystrophin Test	M	10mg	C
<input type="checkbox"/> 238	Complete Congenital Muscular Dystrophy (CMD) Evaluation* (LAMA2, POMT1, POMT2, POMGNT1, FKRP, FCMD Seq. only (single insertion test not available))	B	2-4ml	L
<input type="checkbox"/> 237	Syndromic Congenital Muscular Dystrophy (CMD) Evaluation* (POMT1, POMT2, POMGNT1, FCMD)	B	2-4ml	L
<input type="checkbox"/> 236	Non-Syndromic Congenital Muscular Dystrophy (CMD) Evaluation* (LAMA2, FKRP)	B	2-4ml	L
<input type="checkbox"/> 216	FKRP (for CMD) DNA Sequencing Test*	B	2-4ml	L
<input type="checkbox"/> 217	LAMA2 DNA Sequencing Test*	B	2-4ml	L
<input type="checkbox"/> 218	POMT1 DNA Sequencing Test*	B	2-4ml	L
<input type="checkbox"/> 219	POMT2 DNA Sequencing Test*	B	2-4ml	L
<input type="checkbox"/> 220	POMGNT1 DNA Sequencing Test*	B	2-4ml	L
<input type="checkbox"/> 232	FCMD DNA Sequencing Test*	B	2-4ml	L
<input type="checkbox"/> 147	Complete Myotonia Evaluation* (DM1, DM2, CLCN1, SCN4A)	B	10ml	L
<input type="checkbox"/> 207	Early Onset Myotonia Evaluation* (DM1, CLCN1, SCN4A)	B	10ml	L
<input type="checkbox"/> 108	DM1 DNA Test	<input type="checkbox"/> 110	DM2 DNA Test*	B 10ml L
<input type="checkbox"/> 128	CLCN1 DNA Test*	<input type="checkbox"/> 146	SCN4A DNA Test*	B 10ml L
<input type="checkbox"/> 669	Emery-Dreifuss Muscular Dystrophy Evaluation* (EMD, FHL1, LMNA/C)	B	10ml	L
<input type="checkbox"/> 567	EMD DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 574	FHL1 DNA Sequencing Test*	B	10ml	L
<input type="checkbox"/> 601	Limb Girdle Muscular Dystrophy Evaluation* (CAPN3, CAV3, Dysferlin Seq., FKRP, LMNA, SGCA, B, G, D)	B	20ml	L
Individual Limb Girdle Muscular Dystrophy Tests:		B	10ml	L
<input type="checkbox"/> 562	FKRP*	<input type="checkbox"/> 563	CAPN3	
<input type="checkbox"/> 565	LMNA*	<input type="checkbox"/> 566	CAV3*	
<input type="checkbox"/> 568	Sarcoglycans (SGCA, B, G, D)*			
<input type="checkbox"/> 561	Dysferlin Blood Test* <i>(must arrive on cold pack)</i>	B	15ml	L
<input type="checkbox"/> 571	Dysferlin Sequencing Test*	B	10ml	L
<input type="checkbox"/> 405	FSHD DNA Test*	B	20ml	L
<input type="checkbox"/> 300	OPMD DNA Test*	B	10ml	L
<input type="checkbox"/> 500	Mitochondrial Enzyme Deficiency Myopathy Panel (COX; Rotenone sensitive NADH reductase; Succinate dehydrogenase; Total protein; NADH dehydrogenase; Citrate synthase; Succinate-cytochrome c reductase)	M	100mg	C
<input type="checkbox"/> 501	Myoglobinuria Test Panel (LDH, PGM, PGK, Glycogen, Ph, PhK, PFK, MAD, CPT2)	M	250mg	C
<input type="checkbox"/> 502	Glycogen Storage Myopathy 'A' Profile (Glycogen, Acid and neutral maltase, Debrancher)	M	200mg	C
<input type="checkbox"/> 503	Glycogen Storage Myopathy 'B' Profile (PhK, PFK)	M	200mg	C
<input type="checkbox"/> 504	Lipid Storage Myopathy Profile (Carnitine free & total)	M	100mg	C
<input type="checkbox"/> 519	Mitochondrial Myopathy mtDNA Evaluation* (MELAS, MERRF, NARP)	B	20ml	L
<input type="checkbox"/> 517	MELAS mtDNA Evaluation* (MELAS 3243, 3271, 3252, 3256, 3291, 13513)	B	20ml	L
<input type="checkbox"/> 518	MERRF mtDNA Evaluation (MERRF 8344, 8356, 8296, 8363)	B	20ml	L
<input type="checkbox"/> 516	NARP mtDNA Evaluation (NARP 8993)	B	20ml	L
<input type="checkbox"/> 514	KSS/CPEO mtDNA Profile	M	100mg	C
<input type="checkbox"/> 515	LHON mtDNA Profile* (LHON 11778, 3460, 15257, 14484)	B	20ml	L

Test Code	Preferred Specimen	Minimum Volume	Tube Type
<input type="checkbox"/> 490 Optic Atrophy Evaluation (OPA1)	B	20ml	L
<input type="checkbox"/> 635 Neurofibromatosis Type 2 DNA Test†	B	20ml	L
<input type="checkbox"/> 600 Peroxisomal Disorders Test† (VLCFA, Phytanic acid)	Please Call		
Paraneoplastic Syndromes			
<input type="checkbox"/> 437 NeoComplete Paraneoplastic Profile with Recombx™ (Reflexive) Testing is performed in this order: Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, VGCC, VGKC, Amphiphysin, nAChR, NR1, GAD. Test will reflex to GAD if all other antibodies are negative.	S	5ml	R
<input type="checkbox"/> 438 NeoCerebellar Degeneration Paraneoplastic Profile with Recombx™ (Hu, Yo, Zic4, CV2, MaTa, Ri, Amphiphysin, GAD)	S	3ml	R
<input type="checkbox"/> 439 NeoEncephalitis Paraneoplastic Profile with Recombx™ (Hu, CV2, MaTa, VGKC, Amphiphysin, NR1, GAD)	S	2ml	R
<input type="checkbox"/> 436 NeoSensory Neuropathy Paraneoplastic Profile with Recombx™ (Hu, CV2, Amphiphysin)	S	2ml	R
Individual Recombx™ Antibody Tests:			
<input type="checkbox"/> 118 CAR <input type="checkbox"/> 123 CV2 <input type="checkbox"/> 120 Hu			
<input type="checkbox"/> 122 MaTa <input type="checkbox"/> 115 Ri <input type="checkbox"/> 125 Yo			
<input type="checkbox"/> 127 Zic4			
<input type="checkbox"/> 419 NR1 Antibody Test	S	1ml	R
<input type="checkbox"/> 422 GAD Antibody Test	S	2ml	R
<input type="checkbox"/> 475 LEMS (VGCC) Antibody Test	S	2ml	R
<input type="checkbox"/> 485 VGKC Antibody Test	S	2ml	R
<input type="checkbox"/> 427 Amphiphysin Antibody Test	S	2ml	R
<input type="checkbox"/> 428 Ganglionic AChR (nAChR) Antibody Test	S	2ml	R
Peripheral Neuropathy: Autoimmune			
<input type="checkbox"/> 287 SensoriMotor Neuropathy Profile-Complete (Co-GM1 Quattro®, MAG 'Dual Antigen'®, Hu, GALOP™, Sulfatide)	S	2ml	R
<input type="checkbox"/> 263 Sensory Neuropathy Profile-xp (MAG 'Dual Antigen'®, Hu, GALOP™, Sulfatide)	S	2ml	R
<input type="checkbox"/> 288 Motor Neuropathy Profile-Complete (Co-GM1 Quattro®, MAG 'Dual Antigen'®)	S	2ml	R
<input type="checkbox"/> 289 Multifocal Neuropathy Evaluation (Co-GM1 Quattro®, PMP22 Duplication/Deletion)	S, B	2ml, 20ml	R, L
<input type="checkbox"/> 234 Small Fiber Painful Axonal Neuropathy Profile (Hu, Sulfatide, TTR)	S, B	2ml, 20ml	R, L
<input type="checkbox"/> 277 Co-GM1 Quattro® Antibody Test	S	2ml	R
<input type="checkbox"/> 145 MAG 'Dual Antigen'® Antibody Test	S	2ml	R
<input type="checkbox"/> 261 GALOP™ Antibody Test	S	2ml	R
<input type="checkbox"/> 210 Sulfatide Antibody Test	S	2ml	R
<input type="checkbox"/> 160 GQ1b Antibody Test	S	2ml	R
<input type="checkbox"/> 278 GD1a Antibody Test	S	2ml	R
Peripheral Neuropathy: Hereditary			
<input type="checkbox"/> 404 Complete CMT Evaluation (Includes all individual CMT DNA tests, see below)	B	20ml	L
<input type="checkbox"/> 414 Dominant CMT Evaluation (Cx32, Cx32 Del., MPZ, EGR2, NFL, PMP22, LITAF/SIMPLE, MFN2, PMP22 Dup./Del., RAB7, GARS, HSPB1)	B	20ml	L

Test Code	Preferred Specimen	Minimum Volume	Tube Type
<input type="checkbox"/> 407 Partial CMT – Demyelinating Only (Cx32, Cx32 Del., MPZ, EGR2, PMP22, PMP22 Dupl./Del., GDAP1, PRX, LITAF/SIMPLE, SH3TC2)	B	20ml	L
<input type="checkbox"/> 413 Partial CMT – Axonal Only (Cx32, Cx32 Deletion, MPZ, NFL, GDAP1, MFN2, RAB7, GARS, HSPB1, LMNA)	B	20ml	L
<input type="checkbox"/> 409 Partial CMT – Recessive Only (PRX, EGR2, GDAP1, SH3TC2, FIG4, LMNA)	B	20ml	L
<input type="checkbox"/> 243 Complete HNPP Evaluation (PMP22, PMP22 Dup./Del.)	B	20ml	L
<input type="checkbox"/> 286 Complete Dejerine-Sottas Neuropathy Evaluation (MPZ, EGR2, PMP22, PRX)	B	20ml	L
<input type="checkbox"/> 347 Chronic Demyelinating Neuropathy Profile (MAG 'Dual Antigen'®, GD1b, PMP22 Dup./Del., Cx32, Cx32 Del.)	S, B	2ml, 20ml	R, L
<input type="checkbox"/> 245 Congenital Hypomyelination Evaluation (MPZ, EGR2)	B	20ml	L
<input type="checkbox"/> 296 Entrapment Neuropathy Evaluation (PMP22, PMP22 Dup./Del., TTR)	B	20ml	L
<input type="checkbox"/> 235 Amyloidosis Evaluation (TTR)	B	20ml	L
Individual CMT DNA Tests:			
<input type="checkbox"/> 221 GDAP1 (CMT2K, 4A)	<input type="checkbox"/> 222 LITAF/SIMPLE (CMT1C)*		
<input type="checkbox"/> 223 MFN2 (CMT2A2)	<input type="checkbox"/> 239 Periaxin (CMT4F)		
<input type="checkbox"/> 247 PMP22 Sequencing	<input type="checkbox"/> 248 EGR2 (CMT1D)		
<input type="checkbox"/> 249 NFL (CMT2E, 1F)	<input type="checkbox"/> 131 PMP22 Dup./Del. (CMT1A)		
<input type="checkbox"/> 134 MPZ (CMT1B, 2I, 2J)	<input type="checkbox"/> 226 LMNA (CMT2B1, 4C1)		
<input type="checkbox"/> 224 SH3TC2 (CMT4C)	<input type="checkbox"/> 227 RAB7 (CMT2B)		
<input type="checkbox"/> 225 FIG4 (CMT4J)	<input type="checkbox"/> 228 GARS (CMT2D)		
<input type="checkbox"/> 143 Cx32 Seq./Del. (CMTX)	<input type="checkbox"/> 229 HSPB1 (CMT2F)		
Stroke/Thrombosis			
<input type="checkbox"/> 421 Complete CADASIL Evaluation*	B	10ml	L
<input type="checkbox"/> 090 THROMBOGENE V® Test (Factor V)*	B	10ml	L
<input type="checkbox"/> 098 THROMBX® Evaluation Profile I (Factor V, ATIII function, Protein C function, Protein S function, Anticardiolipin: IgG, IgM, IgA screen)*	B, S	10ml, 2ml	L, R
<input type="checkbox"/> 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)	B, S	10ml, 2ml	L, R
Drug Monitoring			
<input type="checkbox"/> 113 Botulinum Toxin Type A Antibody Test	S	2ml	R

*Medicare ABN required. †Test not available from Athena Diagnostics for Medicare patients.

Specimen Type	Tube Type	
C – CSF	M – Muscle Tissue	P – Polypropylene CSF Transfer Tube
B – Blood	P – Plasma	G – Green B – Blue R – Red
S – Serum		L – Lavender C – Cryovial

NOTE: Two forms of patient ID must be listed on EACH specimen tube.

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.)



Testing that Makes a Difference.

Four Biotech Park, 377 Plantation Street
Worcester, MA 01605 • www.AthenaDiagnostics.com

ADX144SG-7/10AK-REV27

Licensing/Credentials: FID #: 31-1805826, CLIA #: 22D0069726, Medicare #: GE228388 © 2010 Athena Diagnostics, Inc. • Athena Diagnostics, the Athena Diagnostics logo, ADmark, BAbScreen, Co-GM1 Quattro, MAG 'Dual Antigen', NAbFeron, THROMBX and THROMBOGENE V are registered trademarks of Athena Diagnostics, Inc. Access Athena, GALOP, OtoDx and Recombx are trademarks of Athena Diagnostics, Inc. Tysabri is a registered trademark of Elan Pharmaceuticals, Inc.

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