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

Courtagen LIFE SCIENCES, INC.

Epilepsy & Seizure Test Panels
- ❑ epiSEEK Triome† (~1,100 genes)
- ❑ epiSEEK Comprehensive (471 genes)
- ❑ epiSEEK Focus (76 genes)
- ❑ Additional rxSEEK Epilepsy Report
  drug metabolism report for any epiSEEK test
- ❑ Absence Seizures (11 genes)
- ❑ Aicardi-Goutieres Syndrome (7 genes)
- ❑ Benign Epilepsies (15 genes)
- ❑ Brain Malformation Seizures (29 genes)
- ❑ EIEE (Epileptic Encephalopathy) (23 genes)
- ❑ Fever Sensitive Seizures (13 genes)
- ❑ Focal Seizures (15 genes)
- ❑ Infantile Spasms (18 genes)
- ❑ Myoclonic A (Progressive) (21 genes)
- ❑ Myoclonic B (Other) (18 genes)
- ❑ Neonatal Seizures (26 genes)
- ❑ Treatable Seizures (51 genes)

Mitochondrial Test Panels
- ❑ mtSEEK (37 mito. DNA genes)
- ❑ nucSEEK Comprehensive (~1,200 genes)
- ❑ nucSEEK Focus (181 genes)
- ❑ Classic Mito. Disorders (24 genes)
- ❑ Leigh Syndrome (30 genes)

Neurological Test Panels
- ❑ Neuromuscular Comprehensive (305 genes)
- ❑ Centronuclear Myopathy (6 genes)
- ❑ Congenital Musc. Dystrophy (25 genes)
- ❑ Congenital Myasthenia (21 genes)
- ❑ Congenital Myopathy (27 genes)
- ❑ Distal Myopathy (19 genes)
- ❑ Dystonia (19 genes)
- ❑ Hereditary Spastic Paraplegia (58 genes)
- ❑ Limb-Girdle Musc. Dystrophy (30 genes)
- ❑ Migraine (12 genes)
- ❑ Myofibrillar Myopathy (8 genes)
- ❑ Myopathy with Contractures (5 genes)
- ❑ Neuropathic Pain (10 genes)
- ❑ Periodic Paralysis (6 genes)
- ❑ Rhabdomyolysis (39 genes)

Endocrine Test Panels
- ❑ Bone Disorders/O.I. Focus (62 genes)
- ❑ Abnormal Glucose/MODY+ (31 genes)
- ❑ Bardet-Biedl Syndrome (16 genes)
- ❑ Hereditary Pancreatitis (6 genes)
- ❑ Hyperparathyroidism (6 genes)
- ❑ Hypogonadotropic Hypogonadism / Kallmann Syndrome (11 genes)
- ❑ Monogenic Obesity (33 genes)
- ❑ Osteogenesis Imperfecta (12 genes)
- ❑ Pituitary Hormone Deficiency (5 genes)

Multi-system/Syndromic Test Panels
- ❑ theraSEEK# (298 genes)
- ❑ Connective Tissue Focus (84 genes)
- ❑ Ciliopathy Focus (153 genes)
- ❑ Autoinflammatory Disorders (28 genes)
- ❑ COACH Syndrome (3 genes)
- ❑ Cystic Lung Disease (11 genes)
- ❑ Congen. Disord. Glycosylation (39 genes)
- ❑ Immune Dysregulation Disord. (23 genes)
- ❑ Joubert Syndrome (30 genes)
- ❑ Meckel-Gruber Syndrome (12 genes)
- ❑ Noonan / RASopathies (13 genes)
- ❑ Pri. Ciliary Dyskinesia (35 genes)
- ❑ Pri. Ciliary Dyskinesia w/CFTR (36 genes)
- ❑ Senior-Loken Syndrome (9 genes)
- ❑ Short Stature (10 genes)
- ❑ Tuberous Sclerosis Complex (2 genes)
- ❑ Abdominal Pain (42 genes)
- ❑ Ehlers-Danlos (10 genes)
- ❑ Ehlers-Danlos, atypical (11 genes)
- ❑ Hereditary Hemochromatosis (5 genes)
- ❑ Periodic Fever Syndromes (11 genes)
- ❑ Porphyria (10 genes)
- ❑ Stickler Syndrome (6 genes)

Neurodevelopmental Test Panels
- ❑ devSEEK Triome† (1,100+ genes)
- ❑ devSEEK/devACT Comp. (475 genes)
- ❑ devSEEK (237 genes)
- ❑ devACT (267 genes)
- ❑ lysoSEEK (95 genes)
- ❑ Holoprosencephaly (7 genes)
- ❑ Lissencephaly (8 genes)
- ❑ Microcephaly (22 genes)
- ❑ NCL/Battens Disease (13 genes)
- ❑ Urea Cycle Disorders (6 genes)
- ❑ Vanishing White Matter (5 genes)
- ❑ Zellweger Spectrum (12 genes)

Test Add-ons
- ❑ Additional SNP Analysis#
  can be added to any test, except mtSEEK
- ❑ Targeted Parental Testing
  insurance not accepted

† Triome requires patient & both parent samples
# Includes 60 SNPs on report/1,100+ in data file

Single Gene Tests
Write in single gene tests below - please print clearly. A full list of genes is available at:
www.courtagen.com/single-gene-menu.htm

Single Gene Tests / Additional Ordering Instructions

_____

_____

Patient Identification (Required)

Patient Name(First Last/Family) _____

Birth Date _____ Gender: ❑ Male ❑ Female

Mailing Address _____

_____

City, State, Zip _____

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

Name _____

Phone (home/mobile) _____

Email _____

Billing Type

❑ Patient Insurance
❑ Government Account
❑ Self-Pay (credit card required)
❑ Institutional Account

ICD-10 Codes (Required for insurance billing)

Patient Primary Insurance Information

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

Please attach additional documents or secondary insurance information as necessary

Subscriber Name _____ Birth Date _____

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

Insurance Co. Name _____

Member ID _____ Group ID _____

Member Services Phone _____

Physician/Laboratory Contact Information (REQUIRED)

Physician Name _____

Admin Contact _____

NPI/UPIN # _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Email _____

Billing Information (Institutional Accounts)

Purchase Order / Reference: _____

Account: _____

Contact: _____

Email: _____

Address: _____

_____

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

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

Please Sign & Date

_____

Healthcare Professional Signature **Date**

Courtagen Life Sciences Inc.
www.courtagen.com
Phone (U.S.): (877) 395-7608
Phone (Outside U.S.): +1-617-714-0315
Fax: +1-617-892-7192
Email: support@courtagen.com

Courtagen LIFE SCIENCES, INC.

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

❑ Mother's Name _____ Birth Date:_____
❑ YES / ❑ NO: Mother has similar symptoms as patient**
❑ Different address than patient (please include on below)

❑ Father's Name _____ Birth Date _____
❑ YES / ❑ NO: Father has similar symptoms as patient**
❑ Different address than patient (please include on below)

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

** if YES, please describe symptoms on below

Specimen Collection:

Sample type (check one): ❑ saliva ❑ blood ❑ gDNA ❑ muscle
❑ No kit needed _____
❑ Send saliva kit to patient
❑ Send assisted saliva kit (with sponge) to patient
❑ Schedule blood draw with patient

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

Sample Collection Date if not already specified

Patient Clinical Information (Required)

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

Patient Name: _____Birth Date: _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Please Sign & Date

_____
Healthcare Professional Signature **Date**

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