

IBR SPECIALTY CLINICAL LABORATORIES

1050 Forest Hill Road, Staten Island, New York 10314-6399 (718)494-5293 FAX (718)453-7498 fxlab@opwdd.ny.gov CLIA#33D0860102

PATIENT NAME (*Last, First, M.I.*) _____ Date of Birth _____ Gender M F X
 Street Address _____ Phone # _____
 City _____ State _____ Zip _____ Email _____
 ETHNICITY: Caucasian Hispanic Afro American Asian American Indian Other _____

The purpose of this test is to examine a region of DNA within the fragile X gene. The test consists of DNA analysis of the CGG repeat associated with fragile X syndrome, a common cause of inherited intellectual disabilities. A positive test indicates that the individual is a carrier or is affected by fragile X. The test is ~99% accurate, but rare diagnostic errors may occur. No tests other than those authorized or needed to confirm a result shall be performed on the sample and it will be discarded 60 days after receipt unless you give permission below to use any extra sample for research. You may seek genetic counseling if you wish.

I understand the above and give consent for diagnostic testing only:

Name (printed and signature) of Subject or Parent or Guardian Date Witness (printed and signature)

I give permission for any extra sample to be saved and used for future research related to developmental disabilities or distributed to another investigator for the same purpose. I understand that samples will be coded to protect my confidentiality. I understand the research will not include whole genome sequencing. I authorize the laboratory to store such samples for an indefinite period of time. I may, however, withdraw my permission without penalty, at which time the sample will be destroyed.

I understand the above and give consent for diagnostic testing and to use the remaining sample for research:

Name (printed and signature) of Subject or Parent or Guardian Date Witness (printed and signature)

NOTE: The information on this referral form is confidential and is under the protection of the HIPAA Privacy Rule of 1996.
 If it has arrived at the wrong address, please destroy this form and notify us as soon as possible. Thank you.

PATIENT INSURANCE INFORMATION	INSTITUTIONAL BILLING
Name of Policy holder _____ Relationship to patient _____ <i>Attach a copy of both sides of patient's insurance card</i>	Name _____ Address _____ Phone _____ FAX _____

REASON FOR TEST			
Mental Impairment	Yes	No	Fragile X Screening
In a Family member	Yes	No	Fragile X Family History
If yes, name(s) _____			
Other Reason _____			
Positive test for fragile X	Yes	No	
Name(s) _____			
Lab _____			
If yes:	Intermediate	Premutation	Full Mutation
Is a pregnancy involved? _____ EDC _____	Note: We offer free post-natal analysis for all prenatal testing.		

REFERRAL INFORMATION	
Physician name (printed and signature) _____	
Telephone # _____ FAX # _____	Address _____
NPI # _____	City, State, Zip _____
Genetic Counselor	
Telephone # _____	Address _____
FAX # _____	City, State, Zip _____

SPECIMEN TYPE			
Blood: 10 ml lavender tube	Amniotic fluid: 10 ml	CVS 5-10 mg	Collection date: _____
Cultured CV	Cultured AF	Saliva	US date: _____ Gest. age by US date: _____

DIAGNOSIS (<i>check all that apply</i>)				Genetic carrier of other disease	Z14.8
Autism Spectrum Disorder	F84.8	Severe intellectual disabilities	F72	Maternal care for (suspected) hereditary disease in fetus, not applicable or unspecified	O35.2XX0
Mild intellectual disabilities	F70	Profound intellectual disabilities	F73	Family history of intellectual disabilities	Z81.0
Moderate intellectual disabilities	F71	Delayed milestone in childhood	R62.0	Family history of carrier of genetic disease	Z84.81