BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
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1.800.434.9850

CONNECT

BIOCHEMICAL TESTING REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name ______ Patient First Name ______ MI ______ Date of Birth (MM / DD / YYYY) ___ / ___ / ___

Address ______ City ______ State ______ ZIP ______

Phone ______ Accession # ______ Hospital / Medical Record # ______

Biological Sex: ◯ Female ◯ Male ◯ Unknown

Gender identity (if different from above): ______

CURRENT TREATMENT AND DOSAGE*

◯ Glycerol phenylbutyrate ______ mL ______ (frequency)

◯ Sodium phenylbutyrate ______ g ______ (frequency)

MOST RECENT LAB RESULTS*

◯ Plasma ammonia ______ μmol/L

◯ Plasma glutamine ______ μmol/L

UREA CYCLE DISORDER SUBTYPE (DEFICIENCY)*

◯ OTC ◯ CPS1 ◯ ASS ◯ ASL ◯ ARG1 ◯ Citrin ◯ HHH ◯ NAGS

*Optional information.

REPORTING RECIPIENTS

Ordering Physician ______ Institution Name ______

Email (Required for International Clients) ______ Phone ______ Fax ______

ADDITIONAL RECIPIENTS

Name ______ Email ______ Fax ______

Name ______ Email ______ Fax ______

SAMPLE INFORMATION

	TEST CODE	SAMPLE TYPE	USE	SAMPLE REQUIREMENTS	SHIPPING CONDITIONS
☐	4650	Plasma	Inform dosage adjustment	Draw blood in a Heparin (green-top) tube(s) and separate as soon as possible. Send 1-2 cc of plasma. Place the specimen directly into the activated NanoCool® shipping box, which maintains refrigeration at 2°C to 8°C for overnight shipping.	Ship refrigerated by overnight carrier in the activated NanoCool shipping box on same day of sample collection.
☐	4651	Urine	Assess patient compliance	Send 2-4 cc of a random urine sample. Do not add preservatives. Place the specimen directly into the activated NanoCool shipping box, which maintains refrigeration at 2°C to 8°C for overnight shipping.	Ship refrigerated by overnight carrier in the activated NanoCool shipping box on same day of sample collection.

DATE OF COLLECTION ___ / ___ / ___ Date (MM / DD / YYYY)

TIME OF COLLECTION* ______ AM/PM

*Optional information.

TIME OF LAST PHENYLBUTYRATE DOSE* ______ (day) ______ AM/PM

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name ______ Physician's Signature ______ Date (MM / DD / YYYY) ___ / ___ / ___

BILLING INFORMATION

Metabolite testing will be billed to Horizon Therapeutics, LLC.

☐ Check the box if you prefer to be billed directly.

AUTHORIZATION TO SHARE PHYSICIAN CONTACT INFORMATION

As the ordering physician of this test, I hereby authorize Baylor Genetics to disclose my name, address, and telephone number to Horizon Therapeutics, LLC and its affiliates and their respective agents and representatives. I understand that by checking this box my information will be disclosed to Horizon Therapeutics, LLC.

☐ I authorize Baylor Genetics to provide my name, address, and phone number to Horizon Therapeutics, LLC and its affiliates and their respective agents and representatives.

Physician's Printed Name ______ Physician's Signature ______ Date (MM / DD / YYYY) ___ / ___ / ___

Abbreviations: ARG1, arginase 1; ASL, argininosuccinate lyase; ASS, argininosuccinate synthetase; CPS1, carbamyl phosphate synthetase; HHH, hyperornithinemia-hyperammonemia-homocitrullinuria; NAGS, *N*-acetylglutamate synthase; OTC, ornithine transcarbamylase.

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