Revive Genetics Diagnostics Laboratory

CLIA: 10D2337214

Neurological Panel

Requisition & Consent Form

Patient Information

Last Name	First Name	DOB	Sex	MRN

Address	City	State	Zip	Phone Number

Email

Ethnicity ☐ African American ☐ Ashkenazi Jewish ☐ East Asian ☐ Hispanic ☐ Middle Eastern ☐ White ☐ Other

Insurance/Billing Information

Insurance Name	Member ID	Group ID

Primary Name	Primary DOB	Relationship
		☐ Self ☐ Spouse ☐ Child

Ordering Provider/ Facility

Provider Name	NPI	Facility Name	Email

Address	City	State	Zip	Phone Number

Specimen Information

Specimen Type

Collector Name	Collection Date/ Time	Collection Site
		☐ Office ☐ Lab ☐ Home ☐ Other

Confirmation of Medical Necessity for Genetic Testing

I certify that I am a licensed healthcare provider (or authorized representative/genetic counselor) ordering **neurological genetic testing**. I confirm that the patient has been informed of the purpose, scope, limitations, and potential risks of this testing, has had the opportunity to ask questions and seek genetic counseling, and has provided informed consent, which is on file. I attest that this testing is medically necessary and will be used in the clinical management of the patient. I further confirm that the patient authorizes **Revive Genetics** to release relevant information to third-party payors for reimbursement purposes, to receive direct payment for services rendered, and, where applicable, to act as the patient's designated representative for insurance appeals. I acknowledge that the patient understands and accepts financial responsibility for any amounts not covered by insurance, including payments made directly to the patient.

Medical Professional Signature: _____ **Date:** _____

Print Name: _____

Website www.revivegenetics.us Email info@revivegenetics.us	Address 9000 SW 152nd St Suite107, Palmetto Bay, FL 33157	Lab Director Uzma Farooq, MD	Phone Number 786-250-3419

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Test Selection

Select	Panel	Genes	Brief Description
	Express Gene™ Comprehensive Neurological Disorder, Parkinson's Disease, Ataxia and Dementia Panel	185 Genes	Investigates genetic causes of neurological disorders, including Parkinson's disease, hereditary ataxia, dementia, ALS, CMT, hereditary spastic paraplegia, and related neurodegenerative disorders.
	Express Gene™ Hereditary Ataxia Panel	29 Genes	Genetic panel for inherited ataxias, including spinocerebellar ataxias, Friedreich ataxia, episodic ataxia, and related disorders.
	Express Gene Dementia Panel	22 Genes	Genetic panel for inherited dementia, including Alzheimer's disease, frontotemporal dementia, and related neurodegenerative disorders.
	Express Gene™ ALS, Parkinson's Disease Panel	20 Genes	Genetic panel for inherited amyotrophic lateral sclerosis (ALS), Parkinson's disease, and related movement disorders.
	Express Gene™ Neurological Disorders Panel	50-70 Genes	Genetic panel for inherited neurological disorders, including movement disorders, peripheral neuropathies, hereditary spastic paraplegia, epilepsy, and related conditions.
	Express Gene™ Charcot-Marie-Tooth Disease (CMT), Spastic Paraplegia Panel	25 Genes	Genetic panel for Charcot-Marie-Tooth disease (CMT), hereditary spastic paraplegia, and related peripheral neuropathies.

Indications for Testing (Check All That Apply)

☐ Diagnostics ☐ Family History ☐ Recurrent or Unexplained Infections ☐ Patient Management

Clinical Information

Genetic Testing Done Previously: ☐ Yes ☐ No	If Yes what test:	Date of Previous Test: ____/____/____

The Comprehensive Panel includes all genes listed below. If only specific gene(s) are requested, please select them below.
For the complete list of genes included in each Subpanel, please refer to our company's website:
ACADM, ADNP, AFF2, ALDH7A1, ANG, APOE, APP, APTX, ARSA, ARX, ASPA, ASXL1, ATM, ATN1, ATP13A2, ATP1A2, ATP1A3, ATP7B, ATXN1, ATXN10, ATXN2, ATXN3, ATXN7, ATXN8OS, BCKDHA, BCKDHB, BCL11A, BCS1L, BLM, BSCL2, C10orf2, C12orf4, C9orf72, CACNA1A, CACNA1C, CC2D1A, CDKL5, CHD2, CNOT3, CNTN6, COL4A1, COL4A3BP, COQ2, COX10, CSF1R, CSNK2A1, CSTB, CTNND2, DCTN1, DGUOK, DHCR7, DNMT1, DPYD, EGR2, EHMT1, EIF4G1, EN2, ERBB4, EZH2, FANCC, FBXO11, FBXO7, FMR1, FOXG1, FOXP1, FTSJ1, FUS, FXN, G6PC, GAA, GABRG2, GALT, GAMT, GARS, GATM, GBA, GBE1, GCH1, GJB1, GRIN2A, GRN, HBB, HEXA, HFE, HSPB1, HTRA2, HTT, IKBKAP, KCNQ2, KDM5C, L1CAM, LRRK2, MAPT, MBOAT7, MCOLN1, MECP2, MED12, MFN2, MPV17, MPZ, MTHFR, MTM1, NDP, NDUFA1, NLGN3, NLGN4X, NOTCH3, NPC1, NSD1, NTRK1, NTRK2, OPA1, OPTN, PABPN1, PAH, PARK7, PCDH19, PDGFB, PDHA1, PDSS2, PIK3CA, PINK1, PLA2G6, PLCG2, PMP22, PNKD, POLG, POLG2, PPP2R2B, PRKN, PRKRA, PRNP, PRRT2, PSEN1, PSEN2, PTEN, REEP1, RRM2B, SCN1A, SCN1B, SCN2A, SCN8A, SCO1, SCO2, SETX, SGCE, SLC16A2, SLC25A4, SLC2A1, SLC6A3, SLC6A8, SLC9A6, SMN1, SMN2, SNCA, SNCB, SOD1, SPAST, SPG11, SPTLC1, STXBP1, SUCLA2, SUCLG1, SYNGAP1, TAF1, TARDBP, TAZ, TBP, TCF4, TH, THAP1, TK2, TOR1A, TPP1, TREM2, TSC1, TSC2, TTR, TYMP, TYROBP, UBA1, UCHL1, VPS35, ZEB2, ZNF41

List relevant family history of disease (affected family members and relationship to patient):

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Informed Consent

Consent to Testing and Use of Results

I confirm that the submitted specimen belongs to the identified patient and has been voluntarily provided for analysis by **Revive Genetics**. I authorize the laboratory and my healthcare provider to analyze my clinical and genetic information, perform the ordered neurological genetic testing, release test results to the ordering healthcare provider, and disclose information necessary for billing and reimbursement to my insurance carrier, when applicable.

Consent for Neurological Genetic Testing

Your healthcare provider has ordered a **Neurological Genetic Panel** to evaluate genes associated with inherited neurological disorders. Depending on the test ordered, this may include evaluation for conditions such as neurological disorders, hereditary ataxia, Parkinson's disease, amyotrophic lateral sclerosis (ALS), dementia, Charcot-Marie-Tooth disease (CMT), hereditary spastic paraplegia, peripheral neuropathies, movement disorders, and other inherited neurodegenerative conditions.

Genetic testing may identify disease-causing (pathogenic) variants, likely pathogenic variants, variants of uncertain significance (VUS), or no clinically significant findings. A positive result may help confirm a diagnosis, guide medical management, identify at-risk family members, or provide information regarding inherited disease risk. However, a positive result does not predict the severity, age of onset, or progression of disease, and a negative result does not eliminate the possibility of a genetic disorder.

Please be aware of the following limitations:

This test analyzes only the genes included in the selected panel.

Some genetic changes, including certain repeat expansion disorders, deep intronic variants, balanced chromosomal rearrangements, epigenetic alterations, low-level mosaicism, or variants in genes not included on the panel, may not be detected.

Some neurological disorders are caused by genes or variants that have not yet been discovered or fully understood.

Variants of Uncertain Significance (VUS) may be identified. These findings currently have insufficient evidence to determine whether they are disease-causing and should not be used alone for medical decision-making.

Genetic testing results should always be interpreted together with your personal medical history, family history, physical examination, imaging studies, laboratory findings, and other clinical information.

Additional testing, including targeted testing, repeat expansion analysis, deletion/duplication analysis, or broader genomic testing, may be recommended based on your clinical presentation and family history.

Genetic counseling is recommended before and/or after testing to discuss the potential benefits, limitations, and implications of your results for you and your family members.

By signing this consent form, you acknowledge that:

You understand the purpose, benefits, and limitations of neurological genetic testing.

You understand that testing may identify inherited variants that have implications for your biological relatives.

You understand that results may identify unexpected or uncertain findings that could require additional evaluation.

You understand that your results will be reviewed by your ordering healthcare provider and may be discussed with you by your physician or a qualified genetics professional.

You voluntarily consent to undergo the requested genetic testing.

Methodology Limitations

Next-generation sequencing (NGS) has inherent technical limitations. Certain types of genetic variants may not be detected by this methodology, including some repeat expansions, structural rearrangements, low-level mosaic variants, or variants located in genomic regions with limited sequencing coverage. Testing is limited to the genes and variant types validated for the ordered assay.

All test results are treated as confidential and are released only to the patient, the ordering healthcare provider, and other individuals authorized by the patient or required by law. No tests other than those authorized will be performed. Patient specimens will be retained for up to **60 days** following completion of testing and then destroyed according to laboratory policy unless otherwise required.

I have read this consent form, or it has been read to me. I have received satisfactory answers to my questions and understand that I may ask additional questions at any time. I voluntarily consent to the requested neurological genetic test.

Consent / Insurance Release

By signing this form, I authorize **Revive Genetics** to submit medical information related to this testing to my designated insurance carrier for reimbursement when necessary. I authorize payment of benefits directly to **Revive Genetics**. I understand that I am responsible for any charges not covered by my insurance, including but not limited to non-covered, non-authorized, or denied services. I authorize a copy of this authorization to be used in place of the original.

Patient or Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____

Optional Consent for Research and Future Contact

To improve genetic testing, advance the understanding of inherited neurological disorders, and support future research, I voluntarily authorize **Revive Genetics** to use any remaining specimen, de-identified genetic data, and/or clinical information for research, educational, quality improvement, or laboratory development purposes. My identity will not be disclosed in any publication or research activity.

I also authorize **Revive Genetics** to contact me in the future regarding newly discovered disease-associated genes, updated variant classifications, research opportunities, or clinically relevant follow-up related to my testing.

Participation is voluntary and declining this consent will not affect the performance of my ordered test or my medical care.

Patient or Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____

Medical Professional Signature: _____ **Date:** _____

Print Name: _____

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