mng lab medical neurogenetics
Neurogenetics Redefined

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State of Georgia License # 044-146

TISSUE CULTURE TEST REQUEST FORM

TISSUE CULTURE TESTING

☐ (TC01) Cell line Cryopreservation
☐ (TC03) Thaw and Expand cryopreserved fibroblasts
☐ (TC04) EBV Lymphocyte Transformation & Culture
☐ (TC05) Mycoplasma Detection testing
☐ (TC06) Tissue Culture of skin fibroblasts (includes skin biopsy processing)
☐ CELL LINE HAS BEEN MYCOPLASMA TESTED & RESULTS ARE ENCLOSED

PATIENT/SPECIMEN INFORMATION:

Patient LAST name:		Patient FIRST name:	
Patient ID #:		Collection date (mm/dd/yyyy):	
Date of birth (mm/dd/yyyy):		Specimen type: Please see specimen & shipping requirements found on our website. NO Saturday/Sunday deliveries accepted.	☐whole blood ☐muscle ☐CSF
Gender:	☐Male ☐Female Age:		☐plasma ☐fibroblasts ☐skin
Diagnosis/ICD-9:			☐buccal swab ☐urine ☐DNA _____ (source of DNA)

REFERRING PHYSICIAN INFORMATION:

Referring Physician Name:	SIGNATURE:
Facility/Organization:	PHONE:
Address 1 (Street):	
Address 2 (City, State, Zip):	
Email & Fax (select method for results delivery):	☐Email: ☐Fax:

BILLING: *WE ARE CONTRACTED WITH BCBS, CIGNA, & AETNA AND WILL BILL INSURANCE. PLEASE COMPLETE INSURANCE & BILLING DEMOGRAPHICS FORM FOUND ON OUR WEBSITE AT WWW.MNGLAB.COM. INCLUDE FRONT/BACK COPY OF INSURANCE CARD. FOR NON-CONTRACTED PROVIDERS, WE WILL SEEK APPROVAL FOR TESTING.*

Facility Name accepting bill:	
Billing Contact Person:	
Address 1 (Street):	
Address 2 (City, State, Zip):	
Phone:	Email: Fax:

RESULTS:

	Authorized Results Recipient 1 (Mark box to indicate preference for method of receiving results).	**Authorized Results Recipient 2** (Mark box to indicate preference for method of receiving results).
Name:		
Facility:		
Address 1:		
Address 2:		
Fax: ☐	Phone:	Fax: ☐ Phone:
Email: ☐		Email: ☐

INFORMED CONSENT (FOR NY STATE PATIENTS ONLY):

NY INFORMED CONSENT REQUEST FORM AVAILABLE AT WWW.MNGLAB.COM

If a New York State patient specimen, at least one of the following should be checked:

☐ Informed consent signed by patient and attached
☐ Informed consent for genetic testing on file in physician office
☐ Physician has signed or initials here that the implications of genetic testing were discussed with the patient: _____ INITIAL HERE

ETHNICITY (FOR INTERPRETATION OF GENETIC SEQUENCING):

PLEASE MARK ONE

☐ NW European Caucasian
☐ S European Caucasian
☐ Mixed European Caucasian
☐ Native American Indian
☐ Hispanic
☐ African American
☐ Ashkenazi Jewish
☐ Other Jewish
☐ Asian
☐ Other

Special Instructions:	*For Internal Use only:*
	Date Received:
	MNG Accession #:
	Initials received by: