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Clinical Questionnaire for Noonan Syndrome and RASopathies

Prior authorization questions, call **(866) 248-1265.** / Fax (**855) 711-5699** / Test questions, call (**800) 345-4363.**

Name and title of person completing this form _____

Test Information (this is not an order for a test)

Test Options	Test No.
◯ Noonan Syndrome/RASopathies Panel	**482279**
◯ Noonan Syndrome, Fetal Analysis	**482299**

Test Options	Test No.
◯ Other	

Patient Demographics

Patient's name _____ / Date of birth_____ / Sex: ◯ Male ◯ Female

Patient/guardian phone no. _____ / Patient/guardian email _____

Patient History

Select at least one: ◯ Genetic counseling performed by board-certified genetic counselor or clinical geneticist. If marked, attach genetic counseling report.
◯ Pretest counseling performed by ordering provider or designee in accordance with health plan policies. Post-test counseling will be available

Select all that apply:

Patient should exhibit two or more of the below signs and symptoms, and has not had previous genetic testing

- ◯ Hypertrophic cardiomyopathy
- ◯ Congenital pulmonary valve stenosis
- ◯ Electrocardiogram characteristic of an NSD
- ◯ Facial dysmorphism suggestive of NSD
- ◯ Stature of 3rd to 10th percentile for age and gender
- ◯ Pectus carinatum and/or excavatum
- ◯ Cardiac abnormalities suggestive of NSD
- ◯ Broad thorax/widely-spaced nipples
- ◯ Developmental delay, intellectual disability, or diagnosed learning disability
- ◯ Cryptorchidism
- ◯ Broad or webbed neck
- ◯ Lymphatic dysplasia
- ◯ Coagulopathy confirmed with hematologic studies
- ◯ Skin abnormality characteristic of the NSD
- ◯ Pubertal delay and/or infertility

Prenatal/Fetal Noonan Syndrome

- ◯ Gestational age _____
- ◯ Sex of fetus (if known) ☐ Male ☐ Female
- ◯ Previous chromosome testing not considered diagnostic (attach additional pages if necessary)

Ultrasound findings:

- ◯ Nuchal edema
- ◯ Pulmonary valve stenosis
- ◯ Hypertrophic cardiomyopathy
- ◯ Polyhydramnios
- ◯ Ascites
- ◯ Distended jugular lymphatic sacs
- ◯ Pleural effusion
- ◯ Hydrops fetalis
- ◯ Cardiac anomaly
- ◯ Renal anomaly
- ◯ Facial abnormalities
- ◯ Café au lait macules

Family History (attach additional pages if needed)

- ◯ Patient has a first or second degree relative* with a clinical or suspected diagnosis of Noonan Syndrome
- ◯ Previous pregnancy, loss or birth with ultrasound or congenital findings suggestive of Noonan Syndrome
- ◯ Unknown or limited family history? Please explain (eg, adopted) _____

Genetic Counseling—Ordering provider understands by signing below:
If genetic counseling by a board-certified genetic counselor is required by the health plan prior to laboratory testing but has not occurred as indicated in the Patient History section above, I understand that a referral may be made by the laboratory to a board-certified genetic counselor required or authorized by the health plan.
Such referral is solely related to laboratory testing and does not relieve me of any obligation to seek authorization for my services.

Account No.: _____

Provider Name (print): _____ NPI: _____

Provider Phone No.: _____ Fax No.: _____

_____ / _____
Ordering Provider Signature **Date**

Patient understands by signing below:
Labcorp may use information obtained on this form and other information provided by me and/or my ordering provider or their designee to initiate prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

_____
Patient Signature

_____
Date

*Relationships to consider include parents, siblings, offspring (1st degree), half-brothers/sisters, aunts/uncles, grandparents, grandchildren, nieces/nephews (2nd degree).

Visit labcorp.com for detailed information on genes included in each panel.

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