LCA Use Only.
Please place accessioning sticker here.

Clinical Questionnaire for **Maturity-Onset Diabetes of the Young (MODY)**

Prior authorization questions, call 866-248-1265. / Fax 855-711-5699 / Test questions, call 877-436-3056.

Name and title of person completing this form _____

Test Information (THIS IS NOT AN ORDER FOR A TEST)

Note: For Medicare recipients, a signed ABN must accompany the sample if an ICD-10 Code that supports medical necessity is not provided.						
ICD-10 Diagnosis Code(s) Required						

Test Name	Test No.	Test Information
❍ **Maturity-Onset Diabetes of the Young (MODY)**	**504603**	**Use:** Detect mutations and copy number variants in the coding sequence and exon-intron junctions of the MODY genes in the ADA guidelines: HNF1A, GCK, HNF4A, and HNF1B. **Methodology:** Sanger Sequencing, MLPA

Patient Demographics

Patient's name _____ / Date of birth_____ / Gender: ❍ Male ❍ Female

Patient's Phone No. _____ / Patient's Email _____

Patient History (check all that apply)

❍ **Hyperglycemia,** age at Dx _____ / ❍ **Diabetes,** age at Dx _____ / ❍ **Acanthosis nigricans**

Height _____ / **Weight**_____ / **and/or BMI**_____ / **HbA1c (%)**_____

❍ **Tested for diabetes autoantibodies,** select which antibodies were positive:

❑ GAD-65 ❑ ICA 512 ❑ IAA (Insulin autoantibodies) ❑ ZnT8 antibodies ❑ 1A-2A ❑ None were positive

❍ **Extra-pancreatic manifestations (eg, congenital malformations and other signs of syndromic diabetes)**

❍ **Previous MODY genetic testing; if marked, attach report**

Family History (attach additional pages if needed)

❍ Unknown or limited family history? Please explain (eg, adopted) _____

Relative*	Maternal / Paternal	Diabetes Type	Age At Diagnosis	Known MODY Mutation? If yes, attach lab report.
	❑ / ❑			❑ Yes ❑ No
	❑ / ❑			❑ Yes ❑ No
	❑ / ❑			❑ Yes ❑ No
	❑ / ❑			❑ Yes ❑ No
	❑ / ❑			❑ Yes ❑ No
	❑ / ❑			❑ Yes ❑ No

Ordering provider understands by signing below:
Pretest counseling, which includes an interpretation of family and medical histories; education about inheritance, genetic testing, disease management, prevention, and resources; counseling to promote informed choices and adaptation to the risk or presence of a genetic condition; and counseling for the psychological aspects of genetic testing, has been completed where required by health plan. Post-test counseling will be available.

Account No.: _____

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 his/her 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. LabCorp will attempt to contact me if my estimated out-of-pocket cost is more than $300. Testing may be canceled if LabCorp is unable to reach me. No matter my estimated cost, my actual out-of-pocket cost may be higher or lower than the estimate provided. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

❍ **If marked, in the event I cannot be reached, LabCorp may leave a confidential voicemail message at the telephone number provided on this form.**

_____ / _____
Patient Signature **Date**

LabCorp
www.LabCorp.com

*Relationships to consider include parents, siblings, offspring (1st degree), half-brothers/sisters, aunts/uncles, grandparents, grandchildren, nieces/nephews (2nd degree); first cousins, great-aunts/uncles, great-grandchildren, great grandparents (3rd degree).

Esoterix: TIN: 13-3802358 / NPI: 1962489237
LabCorp: TIN: 84-0611484 / NPI: 1659352276

Endocrine SCIENCES
LabCorp Specialty Testing Group