Complete, print and submit

Reset Form

MAYO CLINIC
Mayo Medical Laboratories

Whole Exome Sequencing Test Request Form

WES/ Whole Exome Sequencing

Submitting Provider/Provider Name Information (required)

Submitting/Referring Provider *(Last, First)*
Phone ( ) _____ – _____ Fax* ( ) _____ – _____
Provider's National I.D. (NPI)
Other Contact/Geneticist/Genetic Counselor *(Last, First)*
Phone ( ) _____ – _____ Fax* ( ) _____ – _____

**Fax number given must be from a fax machine that complies with applicable HIPAA regulation.*

Reason for Referral (required)

ICD-10 Diagnosis Code

Note: It is the client's responsibility to maintain documentation of the order.

New York State Patients: Informed Consent for Genetic Testing

Client Information (required)

Client Name		
Client Account No.		
Client Phone	Client Order No.	
Address		
City	State	Zip Code

Patient Information (required)

Patient ID *(Medical Record No.)*		
Patient Name *(Last, First, Middle)*		
Gender ☐ Male ☐ Female	Birth Date *(Month DD, YYYY)*	
Collection Date *(Month DD, YYYY)*	Time ☐ a.m. ☐ p.m.	
Patient's Street Address		
Phone		
City	State	Zip Code

MML Internal Use Only

Ship specimens to:

Mayo Medical Laboratories
3050 Superior Drive NW
Rochester, MN 55901

Customer Service: 800-533-1710

Billing Information

- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing related questions:
800-447-6424 (US and Canada)
507-266-5490 (outside the US)

Visit www.MayoMedicalLaboratories.com for the most up-to-date test and shipping information.

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