



Pharmacogenetic Testing Requisition

A. ACCOUNT INFORMATION
[Account Name]
[Account Street Address]
[City, State, Zip Code]

B. PATIENT INFORMATION	C. SAMPLE INFORMATION													
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; border-bottom: 1px solid black;">Last Name</td> <td style="width: 10%; border-bottom: 1px solid black;">Gender</td> <td style="width: 60%; border-bottom: 1px solid black;"> <input type="checkbox"/> M <input type="checkbox"/> F </td> </tr> <tr> <td style="border-bottom: 1px solid black;">First Name</td> <td style="border-bottom: 1px solid black;">MI</td> <td style="border-bottom: 1px solid black;">Date of Birth</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Patient ID</td> <td colspan="2" style="border-bottom: 1px solid black;">Date of Injury <small>(Worker's Comp Only)</small></td> </tr> </table> <p style="font-size: small; margin-top: 5px;">*Note: Please attach patient demographics sheet containing patient address and insurance information.</p>	Last Name	Gender	<input type="checkbox"/> M <input type="checkbox"/> F	First Name	MI	Date of Birth	Patient ID	Date of Injury <small>(Worker's Comp Only)</small>		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; border-bottom: 1px solid black;">Requesting Provider</td> <td style="width: 30%; border-bottom: 1px solid black;">Date / Time of Collection</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Diagnosis Codes</td> <td style="border-bottom: 1px solid black;"> <input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance/Self Pay <input type="checkbox"/> HMO/PPO <input type="checkbox"/> Workers Comp Ins. Name: _____ ID/Claim #: _____ Group #: _____ </td> </tr> </table>	Requesting Provider	Date / Time of Collection	Diagnosis Codes	<input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance/Self Pay <input type="checkbox"/> HMO/PPO <input type="checkbox"/> Workers Comp Ins. Name: _____ ID/Claim #: _____ Group #: _____
Last Name	Gender	<input type="checkbox"/> M <input type="checkbox"/> F												
First Name	MI	Date of Birth												
Patient ID	Date of Injury <small>(Worker's Comp Only)</small>													
Requesting Provider	Date / Time of Collection													
Diagnosis Codes	<input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance/Self Pay <input type="checkbox"/> HMO/PPO <input type="checkbox"/> Workers Comp Ins. Name: _____ ID/Claim #: _____ Group #: _____													

D. Physician-Ordered Tests (Check one)	Specimen Type: Buccal Swab Only
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MEDICAL MANAGEMENT PANEL (includes all panels below)

- | | | |
|--|---|--------------------------------------|
| <input type="radio"/> PAIN PANEL | <input type="radio"/> GI PANEL | <input type="radio"/> CYP2C19 ONLY |
| <input type="radio"/> PRE-SURGICAL PANEL | <input type="radio"/> UROLOGY PANEL | <input type="radio"/> CYP2D6 ONLY |
| <input type="radio"/> CARDIOLOGY PANEL | <input type="radio"/> THROMBOSIS RISK PANEL | <input type="radio"/> FACTOR II ONLY |
| <input type="radio"/> PSYCH PANEL | <input type="radio"/> CYP2C9 AND VKORC1 | <input type="radio"/> FACTOR V ONLY |
| <input type="radio"/> PAIN/PSYCH PANEL | <input type="radio"/> RHEUMATOLOGY PANEL | <input type="radio"/> MTHFR ONLY |

MEDICAL MANAGEMENT PANEL - CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, FACTOR II, FACTOR V, MTHFR, VKORC1, SLCO1B1, APOE, CYP1A2, CYP2B6, COMT, OPRM1, ANKK1/DRD2

PAIN PANEL - CYP2C19, CYP2C9, CYP2D6, OPRM1, CYP2B6, CYP1A2, CYP3A4, CYP3A5

PRE-SURGICAL PANEL - CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, OPRM1, FACTOR II, FACTOR V, CYP1A2, CYP2B6

CARDIOLOGY PANEL - CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, FACTOR II, FACTOR V, MTHFR, VKORC1, SLCO1B1, APOE

PSYCH PANEL - CYP2C19, CYP2C9, CYP2D6, COMT, ANKK1/DRD2, CYP1A2, CYP3A4, CYP3A5, MTHFR

PAIN/PSYCH PANEL - CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, COMT, OPRM1, ANKK1/DRD2, CYP2B6, CYP1A2, MTHFR

GI PANEL - CYP2C19, CYP2D6, CYP3A4, CYP3A5

UROLOGY PANEL - CYP2D6, CYP3A4, CYP3A5

THROMBOSIS RISK PANEL - FACTOR II, FACTOR V, MTHFR

RHEUMATOLOGY PANEL - CYP2D6, CYP2C9, CYP2C19, MTHFR, CYP1A2, CYP2B6

E. Signatures Authorizing Testing

By signing my name, I hereby authorize Insight Diagnostics to perform the indicated genetic tests on my sample of DNA. I also acknowledge that I have read the "Informed Consent for Pharmacogenetic Testing" form, and I understand the benefits and limitations of this type of testing. Signing this form authorizes Insight Diagnostics to perform specimen testing, release test results to the ordering physician and Crestar Labs, and bill my insurance provider directly for payment. I further authorize Insight Diagnostics and my physician to release to my insurance company any medical information necessary to process this claim.

Patient Signature	Date	Provider Signature	Date
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NOTICE TO ORDERING PHYSICIAN: Documentation to support medical necessity for all tests ordered should be recorded in the patient's chart. Only tests that are medically necessary and reasonable for the diagnosis or treatment of a Medicare or Medicaid patient will be reimbursed. The Office of the Inspector General takes the position that a person who orders or influences the ordering of medically unnecessary tests for which Medicare or Medicaid reimbursement is claimed may be subject to civil penalties under the False Claims Act.