SDI LABS
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CLIA: 05D2103276 LAB ID: CLF00348025

Molecular Genetics Requisition Form

INSTRUCTIONS

☐ Swab ☐ (L)

1. Please PRINT CLEARLY when providing required information for proper processing.
2. Provide all primary/secondary insurance information; or attach copies of patient insurance cards (front and back) in a face sheet appended to this form.

PATIENT INFORMATION *(required)*

LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH

STREET ADDRESS | CITY | STATE | ZIP CODE

PREFERRED CONTACT PHONE NO. ☐ Home ☐ Mobile ☐ Work

GENDER ☐ Male ☐ Female

RACE/ETHNIC IDENTIFICATION

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Jewish - Ashkenazi ☐ Jewish - Sephardic ☐ Native Amercan ☐ Other:

PATIENT INSURANCE INFORMATION *(required)*

With applicable please include a photocopy of insurance card(s) (both sides); for Self Pay please include a photocopy of a valid credit card (both sides).

PLEASE SELECT A BILLING OPTION & COMPLETE THE INFORMATION BELOW:

☐ Medicare ☐ Medicaid ☐ Insurance ☐ Self Pay ☐ Workers Comp/Auto/LOP ☐ Information Attached

PRIMARY INSURANCE CARRIER | PRIMARY INSURANCE POLICY/ID NO. | PRIMARY INSURANCE GROUP NO.

PATIENT RELATIONSHIP TO INSURED
☐ Self ☐ Spouse ☐ Dependent ☐ Other

SECONDARY INSURANCE CARRIER | SECONDARY INSURANCE POLICY/ID NO. | SECONDARY INSURANCE GROUP NO.

MEDICAL NECESSITY *(check all applicable)*

☐ Drug intolerance and side effects - observed
☐ Drug intolerance and side effects - family history
☐ Treatment - FDA-cleared drug with genetic guidance
☐ Treatment - multiple medications (polypharmacy)
☐ Treatment - medical devices (e.g.stents)
☐ Treatment - resistance and/or lack of efficacy
☐ Vulnerable patient - elderly or infirm
☐ Vulnerable patient - child or adolescent

MEDICATION INFORMATION *(required)*

PATIENT HISTORY / REASON FOR ORDERING TEST / COMMENTS

CURRENT MEDICATIONS (attach list of Current Medications where available)

INTENDED MEDICATIONS

PANEL OPTIONS *(required)*

20000 ☐ Pain Management Panel (CYP 2D6,2C19,2C9,3A4/A5 plus)
20010 ☐ Cardiology Panel (CYP 2C19,2D6,FII,FV,MTHFR)
20020 ☐ Thrombosis Panel (CYP FII,FV,MTHFR)
20030 ☐ Psychiatry Panel (CYP 2D6,2C19)
☐ CYP2D6 ☐ CYP2C19 ☐ CYP2C9 ☐ CYP3A4 & 3A5 Plus
☐ CYP2C9-VKOR-C1 ☐ F11-V MTHFR, APOE

RESULTS RECIPIENT *(optional)*

REPORT DELIVERY (if left blank results will be provided to Auth. Physician ONLY)

☐ Authorizing Physician
Email: _____
Fax: _____

☐ Patient
Email: _____
Fax: _____

PHYSICIAN INFORMATION *(required)*

PRACTICE/CLINIC NAME | NPI NUMBER

PRACTICE/CLINIC ADDRESS

PHONE NO. | EMAIL ADDRESS

ICD-10 Codes for Diagnosis & Symptoms

PHYSICIAN NAME | PHYSICIAN SIGNATURE

PATIENT CONSENT

REIMBURSEMENT: Health 360 Labs and/ or its affiliates will make every reasonable effort to obtain reimbursement for the ordered tests about. I hereby authorize Health 360 Labs and/ or its affiliates to release to Medicare and/or any insurance carrier providing medical benefits to me and any health plan to which I am a member any and all medical or other information necessary for claims purposes. I hereby authorize payment of medical insurance benefits to the party who bills for these claims and accepts assignments. I understand that if my insurance company pays me directly for the services provided by Health 360 Labs and/ or its affiliates that I am responsible for forwarding such payment to Health 360 Labs and/ or its affiliates I understand that I am responsible for all charges including deductible/co-payments as required by my plan.

INFORMED CONSENT OF GENETIC INFORMATION: I consent to having genetic analysis performed and the results of the analysis made available to my physician (where requested). This signed test request form authorized Health 360 Labs and/ or its affiliates to perform the test and disclose the results to my medical practitioner (where requested). No tests other than those requested above will be performed. I authorize Health 360 Labs and/ or its affiliates to retain this specimen for future testing as requested.

PATIENT NAME *(please print)* | PATIENT SIGNATURE | COLLECTION DATE