GENO MOLECULAR LABS DIAGNOSTICS

**Requisition Form**
**Ship Samples, photocopy of Insurance card(s) (Front and Back) and copy of this form to:**

**Genoscientific**
**Durham Center,**
**2 Ethel Road, Suite 203 C, Edison, NJ 08817**
**Tel: (732) 662-5543**
**Fax: (732) 662-5544**

## Patient Information

**Patient**

**Name :**_____

Address:

City: State: Zip:

Please send Patient Chart and demography along with requisition.

## Physician Information

**Physician**

**Name:**_____

Practice Name :

Office Phone: ( ) Fax Number :( )

Office Email:

## Collection Information

Collection Date & Time : _____

Check at least one Box below for a personalized medicine management report:

Specimen Type ☐ Buccal Swab ☐ Other:_____

Swabs rubbed firmly in each cheek and under the gum

## Insurance Information

Patient Insurance Information: Include photocopy of insurance card(s) (both sides) OR complete Insurance section below:

| Medicare Number | Relation Ship to Insured(optional) | |
|---|---|---|
| Primary Insurance | ID Number | Group Number |
| | | |
| Secondary Insurance | ID Number | Group Number |
| | | |

## ☐ Cardiovascular Panel

- ☐ Prothrombin (Factor II)
  - o G20210A Mutation
- ☐ Factor V Leiden Mutation
  - o R506Q Mutation
- ☐ Factor XIII A V34L Variant
- ☐ MTHFR 677 and 1298 Mutations
- ☐ Plasminogen Activator Inhibitor-1, PAI-1(SERPINE1) Genotype
- ☐ ACE Genotyping for Coronary Risk Assessment
- ☐ Interleukin-6 (IL-6) G-174C Polymorphism
- ☐ CYP 450 2D6-Beta Blocker
- ☐ CYP 450 2C19(Plavix)
- ☐ CYP 450 2C9 (Includes VKORC1)

## ☐ Individual Tests

**Warfarin Doing**

- o CYP2C9 (Includes VKORC1)

**Plavix Genotyping**

- ☐ CYP 450 2C19

**Cardio Myopathy**

- ☐ Apo E C112R R158C
- ☐ SLCO1B1*5 allele (Val174Ala)

**Drug Metabolism & Mental health Panel**

- ☐ Beta Blocker CYP 2D6
- ☐ CYP 2c19(Plavix)
- ☐ CYP2C9 (Includes VKORC1)
- ☐ MTHFR 2 mutations
- ☐ 5HT2C

## ☐ General Panels and Profiles–SST

**Cardiac Risk Panel**

- ☐ CMP
- ☐ CBC
- ☐ Hepatic Function Panel
- ☐ Lipid Panel
- ☐ CRP-HS
- ☐ Cardiac Pro-BNP
- ☐ Homocysteinemia
- ☐ Vitamin D-25
- ☐

**OTHER PANELS**

- ☐ Male health Screen 1 3 SST, 1L, U
- ☐ Female Health Screen 1 3 SST, 1L, U
- ☐ Male Hormone Screen 2 SST
- ☐ Female Hormone Screen 2 SST
- ☐ Female Wgt Loss Panel 3 SST, 1L, U
- ☐ Rheumatic Eval. 3 SST, 1L

## PHYSICIAN AUTHORIZATION/1CD–9

### Advance Beneficiary Notice Instructions

All tests on this request form are subject to coverage limitations by Medicare and may require that an advance Beneficiary Notice (ABN) be signed by the patient prior to obtaining the specimen. When ordered tests are likely to be denied by Medicare, please complete a separate ABN with the patient's signature and date; submitting it with this requisition.

### Patient Consent

Request and authorize the CLIA accredited laboratory to perform the below designated test(s) on the DNA sample provided by me. My signature below constitutes my acknowledgement that have read the Patient Information Form which outlines the benefits and limitations of this testing which have been explained to my satisfaction by a qualified health professional. Patient Signature: _____