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: Blood, Buccal Swab Urine, STS

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

☐ Cardiac Panel-Buccal Swab

Cardiac Genotyping Risk Panel

- ☐ Prothrombin (Factor II) G20210A Mutation
- ☐ Factor V Leiden Mutation
- ☐ Factor V Leiden Mutation _HR
- ☐ Factor XIII A V34L
- ☐ MTHFR 677 and 1298 Mutations
- ☐ CYP 2D6 (Beta Blocker)
- ☐ CYP 2C19(Plavix)
- ☐ CYP2C9 (Includes VKORC1)
- ☐ ApoE C112R R158C
- ☐ IL-6 G-174C
- ☐ PAI-1 (SERPINE1) Genotyping
- ☐ ACE Genotyping for Coronary Risk Assessment

Cardiac Risk Panel

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

HLA Typing: Blood EDTA -2.5ml

- ☐ HLA DQ6 and DQ8
- ☐ HLA B27 DNA Typing
- ☐ Celiac Diseases DNA testing

☐ Women's Health-Liquid Cyto

- ☐ **HPV-HR and genotyping by Real-Time PCR**

- ☐ C. trachomatis
- ☐ N. gonorrhoeae
- ☐ Trachomonas Vaginitis
- ☐ Herpes Simplex Viruses 1 and 2:
- ☐ BD Affirm™ (Candida, Gardnerella, and Trichomoniasis)
- ☐ Candida albicans
- ☐ Gardnerella vaginalis
- ☐ Candida glabrata
- ☐ M. genitalium
- ☐ M. hominis
- ☐ U. urealyticum 16S
- ☐ T. gondii

- ☐ Hepatitis C Viral Load Quantitative
- ☐ Hepatitis C Genotype
- ☐ Hepatitis B Viral Load Quantitative

- ☐ Cystic fibrosis mutations panel (liquid-based Pap specimens) 39 or 60 Mutations

Drug Metabolism & Mental health Panel: Buccal Swab

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

☐ Microbiology/Cytology

- ☐ Ova and Parasites
- ☐ C. Difficile Toxin (A & B)
- ☐ GPP Panel
- ☐ **Thin Prep LMP:__/__/__**
- ☐ **Pap Smear**
- ☐ **HPV-HR and genotyping by Real-Time PCR**
- ☐ **C. trachomatis DNA Probe**
- ☐ **N. gonorrhoeae DNA Probe**
- ☐ Blood Culture
- ☐ Genital Culture
- ☐ Throat Culture
- ☐ Urine Culture
- ☐ Wound Culture

OTHER PANELS-3 SST, 1L, U

- ☐ Male health Screen 1
- ☐ Female Health Screen 1
- ☐ Male Hormone Screen
- ☐ Female Hormone Screen
- ☐ Female Wgt Loss Panel
- ☐ Rheumatic Eval

☐ General Panels and Profiles-SST

- ☐ COMP METABOLIC
  GLU, NA, K, CL, CO2, BUN, CREAT Ca, Alp, ALT, AST, Alb,TP, Tbil
- ☐ BASIC METABOLIC
  GLU, NA, K, CL, CO2, BUN, Creat, Ca
- ☐ LIPID PROFILE
  Chlo, Trig, HDL, Calc LDL
- ☐ ELECTROLYTES
  NA, K, CL, CO2
- ☐ HEPATIC PANEL
  Alb, TP, Tbil, Dbill, Alp, ALT, AST
- ☐ RENAL PANEL
  Alb,NA,K,CL,CO2, BUN, Phos, Glu, Creat, Ca
- ☐ ANEMIA PANEL
  CBC, Tetic, Ferritin, VIT B12, Folate, Iron, TIBC
- ☐ THYROID PANEL
  TSH, T4, T3, T3U
- ☐ THYROID AUTOIMMUNE
- ☐ TPO ANTIBODY, TG, TGA
- ☐ Pre-Natal Profile-1
  HbsAg, Rubell(IgG), CBC,RPR,ABO, Rh
- ☐ Pre-Natal Profile-2
  CBC, HgB Electro, HBsAG, HIV 1 &2 AB, RPR, Rubella IgG, ABO/Rh Type, Antibody Screen, Urin Analysis & C/S, Urine Drug Screen 5 Panel, Cystic Fibrosis
- ☐ Acute Hepatitis Panel
  HAVab IgM, HBcAb, IgM, HbsAg, HCV
- ☐ Anti-HCV/Reflex
- ☐ Anti-HAV IgM
- ☐ Anti-HBc
- ☐ HBs Ag/Reflex
- ☐ Anti-HBs

PHYSICIAN AUTHORIZATION/1CD-9	Physician ICD-9 Code(required)

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: _____