Pharmacogenetic Requisition Form

Patient Information (required):

Name: John Smith

DOB (MM, DD, YR) DD/MM/YYYY **Gender** ☒ **Male** ☐ **Female**

Street Address: 21 2nd Street

City, State, Zip: New York_NY_10021-3100

Phone# 12125551234

Imperium DNA Test Order – [ ]

Provides a combinatorial genetic analysis showing the effect that multiple genes *(CYP2D6, CYP2C9, CYP2C19, CYP3A4/3A5, CYP1A2, Factor II, Factor V, MTHFR, OPRM1, SLCO1B1 and VKORC1)* may have on a patient's ability to respond to any one of over 125 of the most commonly prescribed medications.

Practice Name_____

Address _____

☐ **Provider** _____ **NPI #** _____
☐ **Provider** _____ **NPI #** _____

DX Codes (Required)

List all relevant ICD-10 Codes:

1) _____ **2)** _____

3) _____ **4)** _____

5) _____ **6)** _____

Payment Method

☐ **Self Pay** **Medicare/ Tricare** ☐ **Medicaid** ☐ [ ] **Private**

☐ **Workman's Comp**
Injury Date __ / __ / ____ **Employer** _____

Claim # _____

Insurance Information: (Required) – A CLEAR copy of the insurance card(s) front and back

Primary Insurance _____

Subscriber ID # _____

☐ **Self** ☐ **Spouse** ☐ **Dependent** ☐ **Other**

If patient is NOT primary insurance holder, please provide the following

Insured Name _____ **Insured SSN** _____ **DOB** __/ __ /___

Patient Consent

I am voluntarily seeking laboratory services and hereby consent to provide a sample as requested. I have the right to refuse specific tests, but understand this may impact my treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the laboratory my right to insurance benefits that may be payable to me for services provided arising from any insurance policy, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded immediately to the laboratory.

_____

Patient Signature *(Required)*

Medical Necessity

Specifically, the tests ordered herein are medically necessary for this particular patient, given the patient's clinical condition, because the tests assist in the: *(Must check at least one box, but may check more than one box)*

☐ Determination of efficacy of existing medications
☐ Assessment of patient's past adverse drug reaction.
☐ Assessment of potential adverse drug reaction based on one or more of the patient's attributes.
☐ Other: _____

_____

Provider Signature *(Required)*