

Diabetes Test Requisition Form

First Name		Last Name		Middle Initial	Clinic Name	
Social Security #	Date of Birth	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Ethnicity <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other			
Address			City	State	Zip	Phone
INSURANCE: Please provide a legible copy of the front and back of the patient's insurance card. IF NO INSURANCE: <input type="checkbox"/> Self Pay <input type="checkbox"/> WC/Auto (Date of Injury) <input type="checkbox"/> Other						
Name of Insured		Relationship to Patient		Insurance Company/Provider		Member/ID Number Group Number
Collector Name (Print)		Date Collected		Time Collected		Fasting <input type="checkbox"/> Yes <input type="checkbox"/> No
Specimen Type <input type="checkbox"/> OCD-100 (Buccal)		Specimen Storage <input type="checkbox"/> Room Temperature <input type="checkbox"/> Refrigerated		Specimen Shipping <input type="checkbox"/> Room Temperature <input type="checkbox"/> Cooling/Ice Pack		

MOLECULAR DIAGNOSTICS TESTING OPTIONS

Diabetes Genomics Test Please select the Panel to be tested. Please attach patient Medication List.

Diabetes - Obesity Comprehensive NGS

ADRB2, PPARG, CEL, KCNJ11, MC4R, BBS10, HNF1B, INS, PDX1, HNF1A, BBS1, BBS2, GCK, HNF4A, LEPR, ABCC8, CEP290, ADRB3, AGRP, ALMS1, ARL6, BBS12, BBS4, BBS5, BBS7, BBS9, BDNF, CARTPT, EIF2AK3, ENPP1, FOXP3, GHRL, GLIS3, GNAS, LEP, MAGEL2, MKKS, MKS1, NEUROD1, NEUROG3, NTRK2, PCSK1, POMC, PPARGC1B, PTF1A, PYY, RFX6, SDC3, SDCCAG8, SIM1, TRIM32, TTC8, UCP1, UCP3, WDPCP, WFS1 (56 Genes)

MODY Neonatal Diabetes NGS

KCNJ11, PDX1, INS, HNF1A, HNF1B, GCK, HNF4A, GLUD1, ABCC8, AKT2, APPL1, BLK, CEL, CISD2, CP, EIF2AK3, FOXP3, GATA6, GLIS3, HADH, IER3IP1, INSR, KLF11, NEUROD1, NEUROG3, PAX4, PTF1A, RFX6, SLC2A2, WFS1, ZFP57 (31 Genes)

Personal/Family History Questionnaire Please complete Questionnaire

PATIENT'S PERSONAL HISTORY (Hx)

Clinical Details	Personal Hx	Age at Dx
Mosaicism	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Consanguinity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bone Marrow Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Known Chromosomal Gain/Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Known Gene Gain/Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	

FAMILY HISTORY

Relationship	Maternal	Paternal	Cancer Site(s)	Age at Dx
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

Clinical Presentation Please indicate any clinical presentations and/or findings that may be relevant to genetic testing:

- Behavior Conditions Pedigree/Family History
 Phenotypes Physical Symptoms

Clinical Testing Please indicate any clinical testing results and/or findings that may be relevant to genetic testing:

- Karyotype Vision Growth Measurements Imaging
 Previous Genetic Testing Hearing Biochemical Testing Pathology Results

ICD-10 DIAGNOSIS CODES: Additional documentation supporting Medical Necessity may be attached.

- | | |
|--|--|
| <input type="checkbox"/> I11.0 Hypertensive heart disease with heart failure | <input type="checkbox"/> R53.83 Fatigue or Weakness |
| <input type="checkbox"/> Z13.1 Encounter for screening for diabetes mellitus | <input type="checkbox"/> R06.02 Shortness of breath |
| <input type="checkbox"/> R73.09 Other abnormal glucose | <input type="checkbox"/> R11.0 Nausea |
| <input type="checkbox"/> R73.01 Impaired fasting glucose | <input type="checkbox"/> R11.10 Vomiting |
| <input type="checkbox"/> R73.02 Impaired glucose tolerance (oral) | <input type="checkbox"/> R82.4 Acetonuria- High levels of Ketones in the urine |
| <input type="checkbox"/> R73.9 Hyperglycemia, unsp | <input type="checkbox"/> R73.9 Hyperglycemia, unsp |
| <input type="checkbox"/> E66.01 Morbid Obesity due to excess calories | <input type="checkbox"/> R19.6 Halitosis - Fruity-scented breath |
| <input type="checkbox"/> E66.09 Other obesity due to excess of calories | <input type="checkbox"/> R35.0 Frequency of Micturition |
| <input type="checkbox"/> E66.8 Other obesity | <input type="checkbox"/> R68.2 Dry mouth, unsp |
| <input type="checkbox"/> E66.9 Obesity, unsp | <input type="checkbox"/> L85.3 Xerosis cutis |
| <input type="checkbox"/> E66.3 Overweight | <input type="checkbox"/> R41.0 Confusion |
| <input type="checkbox"/> Z68.3X Body mass indexes 30.0-39.9 (adult) | <input type="checkbox"/> R10.0 Acute Abdomen |
| <input type="checkbox"/> Z68.4x Body mass indexes > 40.0 (adult) | <input type="checkbox"/> R23.2 Flushing face |
| <input type="checkbox"/> R63.1 Polydysia | <input type="checkbox"/> Other _____ |

Medical Necessity Required for insurance I, the provider, attest that I am the ordering physician or am authorized under applicable laws and regulations to order genetic testing for the patient. I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder, and that the results will be used in medical management and care decisions for the patient. I further attest that any information entered on this Test Requisition Form, or otherwise provided by me on behalf of the patient, is true and correct to the best of my knowledge, and that the patient has consented to receive communications about his/her genetic test from Mainstream Diagnostic Laboratory.

Patient Informed Consent Patient must consent I, the patient, voluntarily consent to the collection and testing of my sample. I certify that the specimen is fresh and has not been adulterated in any manner. I authorize the laboratory to release the results of this testing to the ordering provider. I further authorize my insurance benefits to be paid directly to Mainstream Diagnostic Laboratory for services rendered. I acknowledge that the lab may be treated as an out-of-network provider. In the event I receive payment for laboratory services from my insurer, I will remit said payment to the lab within 14 days of receipt. I will either endorse the original check, or produce a personal check for the entire payment amount, and forward it to the lab. When selecting Self Pay above, I acknowledge financial responsibility for all lab charges associated with the processing of this test requisition. All rights to the samples will belong to the laboratory conducting the testing. There will be no compensation in the event of an invention resulting from research and development using this sample. I agree to allow my provided samples to be used for the purpose of (diagnosis/research) (development/quality control). I understand that if I agree, any information identifying me will be kept confidential so that it will not be possible to determine from whom the sample was drawn. Your signature on this form indicates that you understand to your satisfaction the information about Mainstream Diagnostic Laboratory and agree to have the test done. In no way does this waive your legal rights or release anyone from their legal and professional responsibilities. If you have further questions concerning matters related to this consent, you may wish to seek professional genetic counseling prior to signing this form. Consultation with a medical geneticist, genetic counselor, or your referring healthcare provider also may be warranted after the test has been completed.

Opt In for Research I give permission for my sample and clinical information to be used in de-identified studies at Mainstream Diagnostic Laboratory and for publication, if Mainstream Diagnostic Laboratory deems it appropriate. I understand that my name and/or other identifying information will NOT be used in or linked to the results of any studies and publications. More information is available at www.mainstreamlab.com.

Provider Name (Print)	Provider NPI #	Clinic Address	Clinic Phone/Fax
Provider Signature	Date	Patient Signature (or Legal Guardian)	Date
X		X	