Mainstream
Diagnostic Laboratory

A CLIA Accredited Laboratory
(844) 995-LABS I info@mainstreamlab.com

PLACE 1 BARCODE ON FORM AND 1 ON SAMPLE (REQUIRED: NAME/DOB)

CHECKLIST:
☐ Demographics/Medication List ☐ ICD-10 Codes ☐ ABN (Medicare)
☐ Physician & Patient Signatures ☐ Copy of Patient Insurance Card

PGx Requisition Form

First Name	*Last Name*	*Middle Initial*	Clinic Name

Social Security # | *Date of Birth* | *Sex* ☐ *F* ☐ *M* | *Ethnicity* ☐ *African American* ☐ *Asian* ☐ *Ashkenazi Jewish* ☐ *Caucasian* ☐ *Hispanic* ☐ *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: ☐ Self Pay ☐ WC/Auto (Date of Injury) ☐ Other

Name of Insured | *Relationship to Patient* | *Insurance Company/Provider* | *Member/ID Number* | *Group Number*

Collector Name (Print) | *Date Collected* | *Time Collected* | *Fasting* ☐ Yes ☐ No

Specimen Type ☐ 0CD-100 (Buccal)

Specimen Storage ☐ Room Temperature ☐ Refrigerated

Specimen Shipping ☐ Room Temperature ☐ Cooling/Ice Pack

MOLECULAR DIAGNOSTICS TESTING OPTIONS

Pharmacogenomics Test (PGx) *Please select the Panel to be tested. Please attach patient Medication List.*

☐ PGx Comprehensive Profile
APOE, COMT, CYP1A2, CYP2B6,CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, FACTORII, FACTORV, MTHFR, OPRM1, SLCO1B1, VKORC1, TPMT

☐ PGx Cardiac Profile
APOE, COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, FACTORII, FACTORV, MTHFR, OPRM1, SLCO1B1, VKORC1

☐ PGx Pain Profile
COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, OPRM1, SLCO1B1

☐ PGx Psychiatric Profile
COMT, CYP1A2,CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, MTHFR, OPRM1, SLCO1B1, VKORC1

PGx Test Rationale *The PGx test was ordered for the patient for the following reason(s): Note: At least one selection is required; check all that apply*

- ☐ *Patient's condition appears difficult to treat as evidenced by therapeutic failure of previous medication trials*
- ☐ *Patient has demonstrated sensitivity or lack of symptom relief with recommended medication dosage*
- ☐ *Patient is on multiple medications for his/her condition which increases the risk for adverse drug reactions*
- ☐ *Patient has been noncompliant with the medication treatment regimen due to adverse drug reactions*
- ☐ *Patient is experiencing unpleasant or Intolerable side effects on their current medication egimen*
- ☐ *Patient has a history of medication sensitivity and/or adverse drug reactions*
- ☐ *Patient is suspected of abusing and/or diverting with current medication(s)*
- ☐ *Initial onset of condition in patient with no pharmacological treatment history for condition*
- ☐ *Other diagnostic or medical reason not noted above Please Explain:*

PGx Test Application *The PGx test result will be utilized by me to determine: Note: At least one selection is required; check all that apply*

- ☐ *Medications to avoid in order to decrease the risk of side effects that could lead to noncompliance or treatment discontinuation by the patient*
- ☐ *Dosing changes required to decrease side effects the patient is experiencing on current medication(s)*
- ☐ *Medications to avoid to decrease or eliminate the risk of serious adverse events known to occur with certain medications or classes of medications used to treat the patient's condition*
- ☐ *Dosing the changes required to reduce the risk of an adverse event(s) occurring or recurring with the medication selected to treat the patient.*
- ☐ *Medication which could be utilized to increase the likelihood of achieving a therapeutic response*
- ☐ *Dosing changes required to optimize therapeutic response on current medication(s)*
- ☐ *Important metabolic interactions resulting from the concomitant use of other prescription medication(s)*
- ☐ *Important metabolic interactions resulting from the concomitant use of other OTC or herbal medication(s)*

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

- ☐ C18.9 Malignant neoplasm of colon, unspecified
- ☐ C91.00 Acute lymphoblastic leukemia not having achieved remission
- ☐ D84.89 Other immunodeficiencies
- ☐ D84.9 Immunodeficiency, unspecified
- ☐ E78.00 Pure hypercholesterolemia, unspecified
- ☐ E78.1 Pure hyperglyceridemia
- ☐ E78.2 Mixed hyperlipidemia
- ☐ F11.23 Opioid dependence with withdrawal
- ☐ F31.9 Bipolar disorder, unspecified
- ☐ F32.9 Major depressive disorder, single episode, unspecified
- ☐ F32.9 Major depressive disorder, single episode, unspecified
- ☐ F33.9 Major depressive disorder, recurrent, unspecified
- ☐ F41.0 Panic disorder [episodic paroxysmal anxiety]
- ☐ F43.11 Post-traumatic stress disorder, acute
- ☐ F43.12 Post-traumatic stress disorder, chronic
- ☐ F60.5 Obsessive-compulsive personality disorder
- ☐ I50.89 Other heart failure
- ☐ I50.9 Heart failure, unspecified
- ☐ I51.3 Intracardiac thrombosis, not elsewhere classified
- ☐ K51.919 Ulcerative colitis, unspecified with unspecified complications
- ☐ N32.81* Overactive bladder
- ☐ N39.0 Urinary tract infection, site not specified
- ☐ T41.0X5A Adverse effect of inhaled anesthetics, initial encounter
- ☐ T41.1X5A Adverse effect of intravenous anesthetics, initial encounter
- ☐ T82.818D Embolism due to vascular prosthetic devices, implants and grafts, subsequent encounter
- ☐ T82.867A Thrombosis due to cardiac prosthetic devices, implants and grafts, initial encounter
- ☐ Z20.6 Contact with and (suspected) exposure to human immunodeficiency virus [HIV]
- ☐ Z21 Asymptomatic human immunodeficiency virus [HIV] infection status
- ☐ Z79.01 Long term (current) use of anticoagulants
- ☐ Z79.02 Long term (current) use of antithrombotics/antiplatelets
- ☐ Z86.39 Personal history of other endocrine, nutritional and metabolic disease
- ☐ Z86.79 Personal history of other diseases of the circulatory system
- ☐ Z95.2 Presence of prosthetic heart valve
- ☐ Z95.4 Presence of other heart-valve replacement
- ☐ Z98.61 Coronary angioplasty status
- ☐ 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 en-dorse 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-identifi ed 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	