

Pulmonary 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

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

Pulmonary Arterial Hypertension

BMPR2, ENG, ACVRL1, SMAD9 (4 genes)

Cystic Lung Disease

SERPINA1, TSC1, TSC2, EFEMP2, ELN, FBLN5, FLCN, LTBP4 (8 genes)

Lung Disorders Comprehensive

CFTR, SERPINA1, PHOX2B, RET, BMPR2, ENG, SCNN1A, SCNN1B, SCNNIG, TSC1, TSC2, FBN1, NAF1, NF1, ABCA3, ACVRL1, AP3B1, ASCL1, BDNF, BLOC1S3, BLOC1S6, CCDC39, CCDC40, DNAAF1, DNAAF2, DNAH11, DNAH5, DNAI1, DNAI2, DNAL1, DTNBP1, EDN3, EFEMP2, ELN, FBLN5, FLCN, GDNF, HPS1, HPS3, HPS4, HPS5, HPS6, LTBP4, MUC5B, NME8, RSPH4A, RSPH9, SFTPA1, SFTPA2, SFTPB, SFTPC, SMAD9, TERC, TERT (54 genes)

Pulmonary 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"/>		
	<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"/> C34.10 Upper lobe unspecified bronchus or lung | <input type="checkbox"/> J44.9 Chronic obstructive pulmonary disease, unspecified |
| <input type="checkbox"/> C34.80 Overlapping sites of unspecified bronchus or lung | <input type="checkbox"/> J90 Pleural effusion, not elsewhere classified |
| <input type="checkbox"/> E84.0 Cystic fibrosis with pulmonary manifestation | <input type="checkbox"/> J81.0 Acute pulmonary edema |
| <input type="checkbox"/> G47.33 Obstructive sleep apnea (adult) (pediatric) | <input type="checkbox"/> J96.00 Acute respiratory failure, unspecified whether with hypoxia or hypercapnia |
| <input type="checkbox"/> I26.99 Other pulmonary embolism without acute cor pulmonale | <input type="checkbox"/> J96.10 Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia |
| <input type="checkbox"/> I27.0 Primary pulmonary hypertension | <input type="checkbox"/> J96.20 Acute/Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia |
| <input type="checkbox"/> J20.0 Acute bronchitis due to Mycoplasma pneumoniae | <input type="checkbox"/> J96.21 Acute/Chronic respiratory failure with hypoxia |
| <input type="checkbox"/> J20.2 Acute bronchitis due to streptococcus | <input type="checkbox"/> J96.22 Acute/Chronic respiratory failure with hypercapnia |
| <input type="checkbox"/> J20.4 Acute bronchitis due to parainfluenza virus | <input type="checkbox"/> R06.2 Wheezing |
| <input type="checkbox"/> J20.5 Acute bronchitis due to respiratory syncytial virus | <input type="checkbox"/> R09.89 Other specified symptoms and signs involving the circulatory and respiratory systems |
| <input type="checkbox"/> J44.1 Obstructive chronic bronchitis, with (acute) exacerbation | <input type="checkbox"/> R05 Cough |
| <input type="checkbox"/> J45.23 Mild Intermittent Asthma with status asthmaticus | <input type="checkbox"/> R07.1 Chest pain on breathing |
| <input type="checkbox"/> J45.31 Mild Persistent Asthma with acute exacerbation | <input type="checkbox"/> R22.2 Localized swelling, mass and lump, trunk (chest mass) (localized swelling of chest) |
| <input type="checkbox"/> J45.40 Moderate persistent Asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> J45.32 Mild Persistent Asthma with status asthmaticus | |
| <input type="checkbox"/> J45.52 Severe persistent Asthma with status asthmaticus | |
| <input type="checkbox"/> J45.50 Severe persistent Asthma | |

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 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	