A DIVISION OF GENESIS CLINICAL DIAGNOSTICS
A MEMBER OF GENESIS BIOTECHNOLOGY GROUP

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CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

Cardiology & Thrombophilia Test Requisition Form

Ordering Physician/Laboratory

(Required: Include the ordering physician's first & last name, NPI, practice name, complete address, phone number and fax number.)

Physician to receive additional result report:

Physician's Signature: | Date:

Genetic Testing Specimen Information

Date Collected (Req.): | Specimen Source: ☒ Blood

Inherited Cardiac Conditions / Cardiovascular Disease

ICD10 codes (Req.):

Must complete clinical information on the back.

1267 ☐ Long QT Syndrome by Next Generation Sequencing (KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP9, SNTA1, ANK2, CALM1, CALM2, KCNJ5)

1224 ☐ Site Specific Analysis (specify variant):_____

Thrombophilia Testing

ICD10 codes (Req.):

1263 ☐ Thrombophilia Panel* by Real-Time PCR
- 1264 ☐ Factor II (F2 20210 G>A)
- 1265 ☐ Factor V Leiden (F5 1601 G>A)
- 1266 ☐ MTHFR Mutations (MTHFR 677 C>T, MTHFR 1298 A>C)

Clinical History:

1. History of stent, deep-vein or pulmonary thrombosis? ☐ Yes ☐ No
2. If female, is patient currently taking oral contraceptives? ☐ Yes ☐ No
3. Is patient pregnant? ☐ Yes ☐ No
4. Is there a strong family history of thrombotic disease? ☐ Yes ☐ No
5. Any relatives with a history of venous thrombosis under age 50? ☐ Yes ☐ No
6. Is patient a female smoker under age 50 with myocardial infarction? ☐ Yes ☐ No
7. Specify below any additional/other history including any previous genetic testing. (Attaching report is preferred)

Other Tests/Panels:

ICD10 codes (required):

For a full menu of testing, please visit www.mdlab

If only Test 3104 is ordered from the Drug-Based Pharmacogenomics section, equivalent Test 1263 will be substituted. If Test 1263 is ordered in conjunction with other Drug-Based Pharmacogenomics tests, equivalent Test 3104 will be substituted.

Patient Information (Please Print)

Name (Last, First) (Required):

In Care of:

Patient Address:

City: | State: | Zip:

Assigned Sex at Birth (Required): ☐ Female ☐ Male | Date of Birth (Required): | Patient ID#:

Phone Number: ☐ Cell Phone ☐ Home Phone

Race: ☐ Alaska Native or American Indian ☐ Asian ☐ Black or African American ☐ Multiracial ☐ Native Hawaiian or other Pacific Islander ☐ Other race ☐ White ☐ Does not wish to disclose ☐ Not provided

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Gender Identity: ☐ Male ☐ Female ☐ Gender nonconforming ☐ Transgender male-to-female ☐ Transgender female-to-male ☐ Does not wish to disclose ☐ Not provided

Sexual Orientation: ☐ Bisexual ☐ Straight ☐ Gay or Lesbian ☐ Something else ☐ Does not wish to disclose ☐ Not provided

Billing Information (Please include a copy of the front & back of card.)

Billing Type: ☐ Patient ☐ Insurance ☐ Client | Relation (Required): ☐ Self ☐ Spouse ☐ Dependant

Insured's Name (if not patient):

Insured's SS#: | Insured's DOB:

Primary Insurance Carrier: | Medicare, Medicaid or Policy ID#:

Claims Address:

Employer/Group Name: | Group#:

Drug-Based Pharmacogenomics

ICD10 codes (Req.):

3101 ☐ **Antiplatelet Agents** - Aspirin, Cilostazol, Clopidogrel, Prasugrel, Ticagrelor (ABCB1, CYP1A2, CYP2B6, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, ITGB3, SLOC1B1)

3102 ☐ **Statins** - Atorvastatin, Fluvastatin, Lovastatin, Pitavastatin, Pravastatin, Rosuvastatin, Simvastatin (ABCB1, ABCG2, APOE, CYP2C9, CYP2D6, CYP3A4, CYP3A5, KIF6, SLCO1B1)

3103 ☐ **Anticlotting Agents**-Acenocoumarol, Coumarol, Fluindione, Phenprocoumon, Warfarin (CYP2C9, CYP2C19, CYP2D6, VKORC1)

3104 ☐ **Thrombophilia** - Susceptibility to Factor II, Factor V Leiden (F2, F5, MTHFR)*

3105 ☐ **Calcium Channel Blockers** - Amlodipine, Nifedipine (CYP3A4, CYP3A5)

3106 ☐ **Beta Blockers** - Bufuralol, Carvedilol, Metoprolol, Propranalol, Talinolol, Timolol (ABCB1, CYP2D6, UGT1A1)

3107 ☐ **Congestive Heart Failure** - Digoxin (ABCB1)

3108 ☐ **Antiarrhythmics** - Flecainide, Propafenone (CYP2D6)

3109 ☐ **Antihypertensives** - Benazepril, Debrisoquine, Enalapril, Irbesartan, Losartan, Olmesartan, Verapamil (ABCB1, CYP2D6, CYP2C9, MTHFR, SLOC1B1)

Clinical History:

Are there known mutations in drug metabolism-related genes within the family?

☐ No family history. ☐ Yes, please specify gene and variant below:
(Please include a copy of the family mutation report.)

Confirmation of Informed Consent and Medical Necessity for Pharmacogenomic Genetic Testing

My signature below acknowledges the patient has been informed about the purpose, limitation and possible risks of genetic testing. The patient has been given the opportunity to ask questions about this consent and seek outside genetic counseling.

If the genetic testing is covered by the patient's health plan and the out-of-pocket expense is less than $150.00, testing will proceed without further delay or additional contact. The patient's signed informed consent is being provided with this requisition. I confirm that this testing is medically necessary for the specified patient and that these results will be used in the medical management and treatment decisions for this patient.

Medical Professional Signature (Req.):_____ Date: _____

Clinical Information (Required for Long QT Syndrome Testing)

History of Cardiac Disease	Age at Dx	Relationship	Maternal	Paternal
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Has known familial mutation testing been previously performed? ☐ No ☐ Yes (Please include a copy of the family mutation report.)

If yes, please indicate:

Gene: _____ Mutation: _____ Name of Proband: _____ Relationship to Proband: _____

Clinical Information (check all that apply):

- ☐ No personal history of cardiovascular disease.
- ☐ Syncope - If yes, provide # episodes: _____ Age of first incident: _____
- ☐ Palpitations.
- ☐ Congenital hearing loss.
- ☐ Cardiac arrest - If yes, provide # episodes: _____ Age of first incident: _____
- ☐ History of cardiomyopathy - If yes, provide # episodes: _____ Age of first incident: _____
- ☐ Wolff-Parkinson-White syndrome (WPW).
- ☐ Prolonged QT interval - If yes, provide interval: _____ msec
- ☐ AV block.
- ☐ Ventricular arrhythmias.
- ☐ Atrial fibrillation.
- ☐ Short QT interval.
- ☐ Rugada syndrome.
- ☐ Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)
- ☐ Other arrhythmia types: _____
- ☐ Additional EKG findings: _____
- ☐ Cardiomyopathy:
  - ☐ Hypertrophic cardiomyopathy (HCM) ☐ Restrictive cardiomyopathy (RCM) ☐ Dilated cardiomyopathy (DCM)
  - ☐ Left Ventricular Non-Compaction cardiomyopathy (LVNC) ☐ Other (specify): _____
- ☐ Cardiovascular Device implantations - If yes:
  - ☐ Pacemaker (PCM) - If yes, age at implantation: _____ ☐ Stent ☐ Other (specify):_____
- ☐ Hyperlipidemia.
- ☐ Previous angioplasty.
- ☐ History of deep-vein or pulmonary thrombosis.
- ☐ Additional/Other History including any previous genetic testing (attaching report is preferred):

Medical Necessity Guidelines:

Physicians must only order tests that they have determined are medically necessary for the diagnosis and treatment of a patient. MDL offers individual tests, as well as a limited number of customized panels. MDL provides practitioners with the flexibility to choose appropriate individual tests for each specimen to assure that the convenience of ordering panels does not impede them from ordering tests/panels that are medically necessary. All tests listed in panels may be ordered individually using this test requisition form. If you choose to order a panel, please make certain that each and every test is medically necessary. If you check off a panel as your choice, MDL understands that the physician has determined that all of the component tests are medically necessary, and will perform, report and bill for all such component tests.

Specimen Collection Platform		TAT*	Stability	Test Additions¥	Specimen Collection
Whole Blood	 Yellow Top Tube (ACD Solution A)	3-5 days	48 hours	30 days to add tests	1. In accordance with the standard operating procedure of your facility, collect blood in two yellow top (ACD solution A) tubes. 2. Allow the tubes to fill properly to ensure the proper blood to anticoagulant ratio. 3. Invert gently several times to mix and prevent clot formation. Do not shake the tubes. Do not centrifuge.

** Up to 72 hours with reflex/antiobiotic resistance testing* *¥ Pending QC review for sufficient specimen volume*

Specimen Pick-up:

- If you have a specimen pick-up for a local courier in the NJ, PA, DE, D.C., MD, VA, KS, MO or Phoenix, AZ area, please call (877) 205-0005 no later than 2 hours prior to the closing of your facility.
- If you have a specimen pick-up, please call your sales representative or MDL customer service at 877.269.0090 no later than 2 hours prior to the closing of your facility.