

PHARMACOGENOMICS TEST REQUISITION FORM

PATIENT INFORMATION		ACCOUNT INFORMATION	
First name	Last name	Account number	Account name
Sex <input type="radio"/> Male <input type="radio"/> Female Gender identification (optional): _____	Date of birth (mm/dd/yy)	Phone	Fax
Ancestry <input type="radio"/> White/Caucasian <input type="radio"/> Hispanic <input type="radio"/> Black/African American <input type="radio"/> Native American <input type="radio"/> East Asian <input type="radio"/> South Asian <input type="radio"/> Middle Eastern <input type="radio"/> Ashkenazi Jewish <input type="radio"/> Other: _____		Address	City
Email		State	Zip code
Address		Country	
City	State	Zip code	
Primary phone		Ordering provider	
		Name	Role/Title
		Phone	NPI
		Email address (for report access)	
		Reporting Preference: <input type="radio"/> Portal <input type="radio"/> Fax <input type="radio"/> Email <input type="radio"/> Care Evolve <small>If unmarked, we will use the account's default preferences or fax to new clients.</small>	
		Additional Reporting Providers <input type="radio"/> Same as ordering provider	

SAMPLE INFORMATION	
Date sample obtained (mm/dd/yy)	Medical record #
<input type="radio"/> Blood <input type="radio"/> Buccal swab <input type="radio"/> Other: _____ <input type="radio"/> DNA: tissue source _____	
Patient has had a blood transfusion <input type="radio"/> Yes <input type="radio"/> No Date of last transfusion: _____ (2-4 weeks of wait time is required for some testing)	
Patient has had an allogenic bone marrow transplant <input type="radio"/> Yes <input type="radio"/> No Fibroblasts are recommended for patients who had an allogenic bone marrow transplant. See www.genedx.com/specimen-requirements for details.	
<input type="radio"/> Treatment-Related RUSH Date: _____	

Name	Role/Title
Phone	NPI
Email address (for report access)	
Additional clinical or laboratory contact (optional)	
Name	Email address (for report access)
SEND ADDITIONAL REPORT COPIES TO	
Healthcare provider/Acct #	Fax #/Email

PATIENT CONSENT
By signing this form I acknowledge as the patient that I have read the attached informed consent document and that I authorize GeneDx to perform genetic testing as described. I have been informed that GeneDx may contact me or my healthcare provider about research opportunities in the future. More information, including the GeneDx Notice of Privacy Policies, is available on GeneDx's website: www.genedx.com
<input type="radio"/> By checking this box, I confirm that I am a New York state resident, and I give permission for GeneDx to retain any remaining sample longer than 60 days after the completion of testing.
<input type="radio"/> Check this box if you wish to opt out of being contacted for research studies.
Signature of patient (required) _____ Date _____

STATEMENT OF MEDICAL NECESSITY
By submission of this test requisition and accompanying sample(s), I: (i) authorize and direct GeneDx to perform the testing indicated; (ii) certify that the person listed as the ordering provider is authorized by law to order the test(s) requested; (iii) the test results will determine my patient's medical management and treatment decisions of this patient's condition on this date of service; (iv) have obtained this patient's and relatives', when applicable, written informed consent to undergo any genetic testing requested.
Signature of provider (required) _____ Date _____

PATIENT STATUS – ONE MUST BE CHECKED: Hospital outpatient Hospital inpatient Date of discharge: _____ Not a hospital patient

PAYMENT OPTIONS	
<input type="radio"/> Patient Bill	Amount (\$): _____
If Patient Bill is selected, I am electing to be treated as a self-pay patient for this testing. I agree that neither GeneDx nor I will submit a claim to my insurance for this testing, if I have insurance. GeneDx will send an invoice to the patient listed above.	
<input type="radio"/> GeneDx Affiliate Code:	
<input type="radio"/> Institutional Bill	GeneDx account # _____ Hospital/Lab name _____
Place sticker/stamp here	

PHARMACOGENOMICS TESTING OPTIONS		
TEST CODE	TEST NAME	MEDICATION GROUPS/DISORDERS
<input type="radio"/> J909	PharmacDx (~150 targeted variants)	Antiarrhythmics, Anticoagulants, Antidepressants, Antidiabetics, Antiepileptics, Antihypertensives, Antipsychotics, Antivirals/Antiretrovirals, Benzodiazepines, Chemotherapeutics, Corticosteroids, General Anesthetics, Immunosuppressants, Inhibitors, Muscle Relaxants, NSAIDs, Opioids, Platelet Aggregation, Proton Pump Inhibitors, Statins, Stimulants

PHARMACOGENOMICS INFORMED CONSENT

Account #	Account Name		
First Name	Last Name	Date of Birth	

General Information About Genetic Testing

What is genetic testing?

DNA provides instructions for our body's growth and development. Genes are distinct sequences of DNA, and are arranged on chromosomes. The DNA in a gene contains instructions for making proteins, which determine things like growth and metabolism as well as traits like eye color and blood type. Genetic disorders are caused by changes in DNA or from changes in the structure or number of chromosomes. Genetic testing is a laboratory test that tries to identify these changes in chromosomes or the DNA. Genetic testing can be a diagnostic test, which is used to identify or rule out a specific genetic condition. Genetic screening tests are used to assess the chance for a person to develop or have a child with a genetic condition. Genetic screening tests are not typically diagnostic and results may require additional diagnostic testing.

GeneDx's PharmacoDx test aids health care providers in the selection of medications that are most likely to be effective and least likely cause side effects. Finding the right drug for patients while trying to manage side effects via a "trial and error method" can be time consuming, expensive, and may result in delayed treatment.

The purpose of this test is to obtain information on predicted drug response to medications based on my genetic makeup. Additional information about the specific test being ordered is available from my health care provider or I can go to the GeneDx website, www.genedx.com.

What could I learn from this genetic test?

The test results will include:

- Predicted response to certain medications, based on my genetic makeup
- Prescribing recommendations based on my predicted response to a medication
- A summary of the evidence behind the prescribing recommendations
- My genotype for each sequenced variant

What are the risks and limitations of this genetic test?

Genetic testing is highly accurate. Rarely, inaccurate results may occur for various reasons. These reasons include, but are not limited to: mislabeled samples, inaccurate reporting of clinical/medical information, rare technical errors, or unusual circumstances such as bone marrow transplantation, or the presence of change(s) in such a small percentage of cells that the change(s) may not be detectable by the test (mosaicism).

- This test does not have the ability to detect long-term medical risks that {I/my child} might experience. The result of this test does not guarantee my health or the health of my child.
- Occasionally, an additional sample may be needed if the initial specimen is not adequate.

Patient Confidentiality and Genetic Counseling

It is recommended that I consult with a physician, pharmacist, genetic counselor, and/or other health care professional before and after having this test. I can find a genetic counselor in my area here: www.nsgc.org. Further testing or additional consultations with a health care provider may be necessary.

To maintain confidentiality, the test results will only be released to the referring health care provider, to the ordering laboratory, to me, to other health care providers involved in {my/my child's} treatment, or to others as entitled by law. The United States Federal Government has enacted several laws that prohibit discrimination based on genetic test results by health insurance companies and employers. In addition, these laws prohibit unauthorized disclosure of this information. For more information, I understand that I can visit www.genome.gov/10002077.

International Specimens

If {I/my child} reside outside the United States, I attest that by providing a sample for testing, I am not knowingly violating any export ban or other legal restriction in the country of {my/my child's} residence.