A Molecular Diagnostics Laboratory

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FOR GENETIC ASSAYS USE ONLY

Accession #:______________________________

Date Received:______________ Time Received:______________

Technician:________________ Total Volume:______________

Client Information

❑ Call ❑ Fax Results to ______________________________

at ______________________________

Patient Information – Laboratory

Patient's Name: ______________________________ (Last, First, MI)

Patient's Social Security #: ______________________________

Patient/Specimen I.D.#:______________________________

Sex:_______ Date of Birth:______________ Age:______________

Date Drawn:______________ Time Drawn: ______________

# of Tubes:__________ Specimen Type:______________________

Ordering Physician:______________ NPI#: ______________

ICD-9 Diagnosis (must be provided): ______________________

Patient has tested positive for ❑ HIV ❑ Hepatitis ❑ Tuberculosis

❑ Other ______________________________

Billing Information

❑ **Bill Client Directly**

No further information necessary

❑ **Bill Patient's Credit Card**

Provide the following information:

Credit Card Number ______________________________

Signature ______________________ Expiration Date ________

❑ **Bill Insurance/Medicare**

*Attach copy of front **and** back of insurance card, or provide information to right:*

Insurance Company: ______________________________

Subscriber Name: ______________________________

Relationship to Insured: ❑ Self ❑ Spouse ❑ Other ______________

ID #:______________ Group #:______________

Insurance Co. Address: ______________________________

City: ______________________ State:________ Zip:__________

Insurance Co. Phone #: ______________________________

Patient's Social Security #: ______________________________

Patient's Address: ______________________________

City: ______________________ State:________ Zip:__________

Home Phone: ______________ Work Phone: ______________

For Medicare and other insured patients: I authorize any holder of medical or other information about me to release to the health care financing administration or its intermediaries or carriers or any other government agency or insurance carrier responsible for payment, any information needed for this or related Medicare or other claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment shown; **(Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (1) of the Medicare Law. There may be certain molecular genetic tests that are ordered which your physician feels are necessary for the maintenance of good health that are not covered by your insurance contract. You will be expected to pay for those services in full.)** I have read your policy and agree to pay for services not covered by my contract as indicated by my signature. I understand that my doctor has ordered molecular genetic tests to be performed by Genetic Assays, Inc. Laboratory.

Patient's Signature (Required):______________________________ Date:______________

Frequently Requested Assays: *For additional testing needs, please call Client Services.*

3701 ❑ **Adenovirus** DNA by Real-time PCR (Quantification)
3700 ❑ **BK Virus** DNA by Real-time PCR (Quantification)
3333/0180 ❑ ***C. trachomatis & N. gonorrhoeae*** DNA by PCR (Qualitative)
3333 ❑ ***Chlamydia trachomatis*** DNA by PCR (Qualitative)
3702 ❑ **Cytomegalovirus (CMV)** DNA by Real-time PCR (Quantification)
4025 ❑ **Enterovirus** RNA by RT-PCR (Qualitative)
6111 ❑ **Epstein-Barr Virus (EBV)** DNA by Real-time PCR (Quantification)
8191 ❑ **H1N1** - Influenza A and 2009 H1N1 by rRT-PCR (Qualitative)
750 ❑ **HCV** RNA by RT-PCR (Qualitative)
219TQ ❑ **HCV** RNA by RT-PCR (Qualitative and Quantification)
8698 ❑ Reflex to **HCV Genotyping**
8698 ❑ **HCV Genotyping**
875TQ ❑ **HIV-1** RNA by RT-PCR (Quantification)
7575 ❑ **HPV Genotyping**
900 ❑ **HSV-1&2** DNA by Real-time PCR (Qualitative)
250 ❑ **Mycobacteria** DNA by PCR (Qualitative)
1000 ❑ Reflex to **Mycobacteria** DNA Sequencing
275 ❑ **Mycobacteria** DNA by PCR w/ AFB Stain & Culture (Qualitative)
1000 ❑ Reflex to **Mycobacteria** DNA Sequencing
0180 ❑ ***Neisseria gonorrhoeae*** DNA by PCR (Qualitative)
1201 ❑ **Respiratory Viral Panel (RVP)** by multiplex RT-PCR (Qualitative)

Women's Health Care – Commonly Ordered Assays

3333/0180 ❑ ***C. trachomatis & N. gonorrhoeae*** DNA by PCR (Qualitative)
3333 ❑ ***Chlamydia trachomatis*** DNA by PCR (Qualitative)
0180 ❑ ***Neisseria gonorrhoeae*** DNA by PCR (Qualitative)
395 ❑ **HPV** DNA by Hybrid Capture 2 (Qualitative)
7575 ❑ Reflex to **HPV Genotyping**
395H ❑ **HPV High Risk Only** DNA by Hybrid Capture 2 (Qualitative)
7575 ❑ Reflex to **HPV Genotyping**
7575 ❑ **HPV Genotyping**
900 ❑ **HSV-1&2** DNA by Real-time PCR (Qualitative)
6262 ❑ **Cystic Fibrosis Mutation Detection**
Racial/Ethnic Background *(Required)* ______________________
Indications for testing *(Please check)*
❍ Diagnostic Testing, diagnosis of CF
❍ Carrier Testing, general population of reproductive couples
❍ Carrier Testing, positive family history
❍ Other: ______________________
Does the patient have a positive family history of CF? ❑Yes ❑No ❑Unknown
IF YES, please list known mutations:______________________

Write in test code # and test name below *(For additional tests)*

________ ______________________________

________ ______________________________

PCR is performed pursuant to a license agreement with Roche Molecular Systems, Inc.

Top Copy - Genetic Assays, Inc. • Bottom Copy - Client