A. ACCOUNT INFORMATION

[Account Name]
[Account Street Address]
[City, State, Zip Code]

CRESTAR LABS
Powered by Insight Diagnostics, LLC

Pharmacogenetic Testing Requisition

B. PATIENT INFORMATION

Last Name | Gender ☐ M ☐ F

First Name | MI | Date of Birth / /

Patient ID | Date of Injury (Worker's Comp Only)

*Note: Please attach patient demographics sheet containing patient address and insurance information.

C. SAMPLE INFORMATION

Requesting Provider | Date / Time of Collection / / : AM PM

Diagnosis Codes

Insurance Information
☐ Medicare ☐ No Insurance/Self Pay
☐ HMO/PPO ☐ Workers Comp
Ins. Name:
ID/Claim #:
Group #:

D. Physician-Ordered Tests (Check one)

Specimen Type: Buccal Swab Only

- O **MEDICAL MANAGEMENT PANEL (includes all panels below)**
- O **PAIN PANEL**
- O **PRE-SURGICAL PANEL**
- O **CARDIOLOGY PANEL**
- O **PSYCH PANEL**
- O **PAIN/PSYCH PANEL**
- O **GI PANEL**
- O **UROLOGY PANEL**
- O **THROMBOSIS RISK PANEL**
- O **RHEUMATOLOGY PANEL**
- O **CYP2C19 ONLY**
- O **CYP2D6 ONLY**
- O **FACTOR II ONLY**
- O **FACTOR V ONLY**
- O **MTHFR ONLY**

MEDICAL MANAGEMENT PANEL - CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, FACTOR II, FACTOR V, MTHFR, VKORC1, SLCO1B1, APOE, CYP1A2, CYP2B6, COMT, OPRM1, ANKK1/DRD2

PAIN PANEL - CYP2C19, CYP2C9, CYP2D6, OPRM1, CYP2B6, CYP1A2, CYP3A4, CYP3A5

PRE-SURGICAL PANEL - CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, OPRM1, FACTOR II, FACTOR V, CYP1A2, CYP2B6

CARDIOLOGY PANEL - CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, FACTOR II, FACTOR V, MTHFR, VKORC1, SLCO1B1, APOE

PSYCH PANEL - CYP2C19, CYP2C9, CYP2D6, COMT, ANKK1/DRD2, CYP1A2, CYP3A4, CYP3A5, MTHFR

PAIN/PSYCH PANEL - CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, COMT, OPRM1, ANKK1/DRD2, CYP2B6, CYP1A2, MTHFR

GI PANEL - CYP2C19, CYP2D6, CYP3A4, CYP3A5

UROLOGY PANEL - CYP2D6, CYP3A4, CYP3A5

THROMBOSIS RISK PANEL - FACTOR II, FACTOR V, MTHFR

RHEUMATOLOGY PANEL - CYP2D6, CYP2C9, CYP2C19, MTHFR, CYP1A2, CYP2B6

E. Signatures Authorizing Testing

By signing my name, I hereby authorize Insight Diagnostics to perform the indicated genetic tests on my sample of DNA. I also acknowledge that I have read the "Informed Consent for Pharmacogenetic Testing" form, and I understand the benefits and limitations of this type of testing. Signing this form authorizes Insight Diagnostics to perform specimen testing, release test results to the ordering physician and Crestar Labs, and bill my insurance provider directly for payment. I further authorize Insight Diagnostics and my physician to release to my insurance company any medical information necessary to process this claim.

Patient Signature	Date	Provider Signature	Date

NOTICE TO ORDERING PHYSICIAN: Documentation to support medical necessity for all tests ordered should be recorded in the patient's chart. Only tests that are medically necessary and reasonable for the diagnosis or treatment of a Medicare or Medicaid patient will be reimbursed. The Office of the Inspector General takes the position that a person who orders or influences the ordering of medically unnecessary tests for which Medicare or Medicaid reimbursement is claimed may be subject to civil penalties under the False Claims Act.