PREMIER GENOMICS
PHARMACOGENOMICS

PHARMACOGENOMICS TEST REQUISITION

PATIENT INFORMATION

Sample Collection Date (MM/DD/YYYY)	Patient Name (Last, First)		Date of Birth
Street Address	City, State, Zip	Contact #	☐ Female ☐ Male

Patient Ethnicity: ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Black ☐ Hispanic ☐ American Indian/ Native Alaskan ☐ Asian ☐ Other/Unknown

☐ Family History (please attach details)

PATIENT HISTORY (please use separate page if necessary)

Allergies

Current Medications

Patient acknowledgement for direct insurance/3rd party billing: I hereby authorize my insurance benefits to be paid directly to lab rendering the test and authorize them to release medical information concerning my testing to my insurer. If applicable, I authorize this lab to be my Designated Representative for purposes of appealing any denial of benefits. I understand that I am financially responsible for any amounts not covered by my insurer for this test order. I also fully understand that I am legally responsible for sending the lab any money received from my health insurance company for performance of this genetic test. Further, I authorize the provider to release any pertinent medical records.

Patient or Legally Authorized Representative | Date | Patient E-mail

ORDERING PHYSICIAN AND/OR OTHER LICENSED MEDICAL PROFESSIONAL

NPI #	Name (Last, First, Degree)	Facility Name
Street Address	City, State, Zip	
Phone	Fax	Email

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING

By ordering testing, the undersigned person represents that he/she is a licensed medical professional authorized to order genetic testing OR is a representative of a licensed medical professional authorized to order genetic testing: acknowledges the patient has been supplied information regarding genetic testing and the patient has given consent for genetic testing to be performed. I request clinical interpretation of these results and confirm that this testing is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome or disorder, and that these results will be used in the medical management and treatment decisions for this patient. My signature here applies to the attached letter of medical necessity (if applicable.) Furthermore, additional results recipients information is true and correct to the best of my knowledge.

Medical Professional Signature | Date

TEST PANELS

PHARMACOGENOMICS

☐ Comprehensive Panel *Cheek Swab*

- ☐ Psychotropic Panel *Cheek Swab* CYP2C19, CYP2D6, CYP2C9, MTHFR, OPRM1, COMT, CYP3A4, CYP3A5, CYP1A2, ANKK1/DRD2
- ☐ Pain Panel *Cheek Swab* CYP2C19, CYP2D6, CYP2C9, CYP3A4, CYP3A5, CYP1A2, CYP2B6
- ☐ Cardiovascular Panel *Cheek Swab* CYP2C19, CYP2D6, CYP2C9, VKORC1, FACTOR II, FACTOR V LEIDEN, MTHFR, CYP3A4, CYP3A5, SLCO1B1

We cannot accept saliva (or blood) for individuals who have undergone bone marrow transplant from a donor, peripheral stem cell transplant, or have a hematologic cancer or Myelodysplatic Syndrome (MDS).