

Test Requisition Form

Targeted Variant Testing

RESET FORM

Person completing form	Contact (direct phone or email)	Date of request (MM/DD/YYYY)
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Patient information

Last (family) name	First name	MI	Date of birth (MM/DD/YYYY)	
Address		City	State / Province	Zip / Postal code
Email	Phone number		Geoancestry / Ethnicity	
Medical record number (MRN)	Biological sex ☐ Male ☐ Female ☐ Other, specify karyotype _____			
Has patient been tested previously at PreventionGenetics? ☐ No ☐ Yes, PG ID _____		Reason for test ☐ Diagnosis / Affected ☐ Carrier Testing / Unaffected ☐ Presymptomatic / At Risk		
Has patient's Relative been tested at PreventionGenetics? ☐ NO ☐ YES, please provide:				

Relative's name and/or PreventionGenetics ID number

Date of birth (MM/DD/YYYY)

Relationship to Patient

If the family member was tested at an outside laboratory, we recommend you submit the outside report and a specimen from the individual to serve as a positive control. If a positive control is not provided, negative results will carry a limitation stating PreventionGenetics did not have the opportunity to verify that we can detect the variant in this family. Please contact client services with questions.

Specimen information

Blood, buccal, saliva, or direct tissue specimens are not accepted for patients with any prior history of allogeneic bone marrow or stem cell transplant or certain types of blood transfusions. In these cases, an alternative specimen—such as extracted DNA from cultured fibroblasts—is required. Learn more at [PreventionGenetics.com/specimens](https://www.preventiongenetics.com/specimens).

Specimen source*Mitochondrial analysis is not available for cord blood or prenatally derived specimens. For prenatally derived specimens order on the Prenatal TRF*

☐ Whole Blood	☐ Buccal	☐ Tissue, Source _____
☐ Saliva	☐ Extracted DNA, Source _____	☐ Other _____
☐ Cultured Cells (non-prenatal), Source _____		

Specimen collection date
(MM/DD/YYYY)☐ Specimen collected in New York State or patient is a resident of New York State

If no collection date is provided, date of receipt will be used.

A signed patient consent is needed to retain samples beyond 60 days. If needed, consent forms can be found on [PreventionGenetics.com](https://www.preventiongenetics.com)**Patient test selection**

PreventionGenetics offers no-cost targeted testing for certain variants classified as a variant of uncertain significance (VUS) in parents of probands tested at our laboratory in order to assist with clarifying interpretation of variants. See our Family Targeted Variant Testing Policy on our website for more information.

Test selection / Test code	Gene(s)	Variant(s) (c./p./g. or CNV information)
☐ 100 (1 variant)		
☐ 200 (2 variants)		
☐ 300 (3 variants)		
☐ 1400 (Known Familial del/dup, PCR) only available for family members of probands who were tested at PreventionGenetics and if we confirmed the del/dup by PCR		
☐ 600 (Del/Dup via aCGH)		
☐ Other _____ Specify Test Code		

Comments or notes to lab

Special instructions

- ☐ **NO charge** Meets Family Targeted Variant Testing policy
- ☐ **STAT Testing** Ideal for patients with critical conditions.
- ☐ **Positive control ONLY**

PATIENT		
Last name	First name	MI

Provider / laboratory contact and reporting

***Our preferred method of report transmission is uploading to our secure web portal, myPrevent Portal.
Please provide an email address, when possible.***

Provider information

Institution				
Address		City	State / Province	Zip / Postal code
Ordering provider (First, Last, Degree)		Requesting genetic counselor or allied provider (First, Last, Degree)		
Email address (For report access via myPrevent Portal)		Email address (For report access via myPrevent Portal)		
Phone number	NPI# (US only)	Phone number	NPI# (US only)	
If you require reports to be transmitted via another secure method, specify here				
List additional Healthcare Providers and their emails to allow access to reports				

As the ordering Healthcare Provider, I certify that: (1) I am a qualified healthcare provider who is legally authorized to order this test and this testing is medically necessary and appropriate for this patient and the results will be used to determine the patient's treatment plan; (2) I have obtained the patient's informed consent in accordance with applicable law for the lab to perform this test; (3) I have received the patient's consent for your laboratory to release test results and submit all necessary information to insurance for payment; and (4) I understand this testing will be based on the most updated requisition and test description available.

Send out laboratory☐ Provide report to send out lab.

Institution / Contact				
Address		City	State / Province	Zip / Postal code
Email address (For report access via myPrevent Portal)		Phone number	NPI# (where applicable)	
If you require reports to be transmitted via another secure method, specify here.				

PATIENT		
Last name	First name	MI

Billing options

Testing will proceed when all billing information has been received.

Check one and fill out the necessary section completely

☐ **Institutional billing**
Complete section 1

☐ **Insurance billing**
Complete section 2

☐ **Patient pay (pre-service)**
Complete section 3

For Canadian providers
☐ **Hold testing for Ministry of Health (MOH) approval**

Section 1 - Institutional billing

Billing institution		PO number (if available)	
Billing contact	Phone number	Email	
Address	City	State / Province	Zip / Postal code
Billing account number (if available)			

Section 2 - Insurance billing

ICD-10 Codes

(Required for insurance billing) **1** Primary _____ **2** _____ **3** _____

Responsible party information

Patient relation to responsible party? ☐ Self (see page one for contact info) ☐ Spouse ☐ Parent ☐ Other

Responsible party's name (If different from patient, must be 18 years or older)		Phone number	
Address	City	State / Province	Zip / Postal code
Email			

Insurance information

Select your insurance type and attach a copy of your primary insurance card (front and back) ☐ Private ☐ TriCare ☐ Medicare Include signed ABN form. ☐ Medicaid

Policy holder name	Date of birth (MM/DD/YYYY)	Relationship to patient	
Primary insurance company name (Required)		Phone number	
Policy ID#	Group #	Authorization # (if available) ☐ Attach a copy of the authorization.	
Provide secondary insurance and attach a copy of the secondary insurance card (front and back)			

Insurance hold options

If neither checkbox is selected, testing will proceed regardless of patient financial responsibility.

☐ **Hold test and contact the patient with cost estimate.**

If we are unable to connect with the patient after multiple attempts, we will proceed with testing to avoid delays in patient care.

☐ **Proceed with test regardless of patient responsibility.**

Section 3 - Patient pay (pre-service)

Our billing team will connect with the responsible party to collect the payment.

Responsible party information

Patient relation to responsible party? ☐ Self (see page one for contact info) ☐ Spouse ☐ Parent ☐ Other

Responsible party's name (If different from patient, must be 18 years or older)		Phone number	
Address	City	State / Province	Zip / Postal code
Email			