

TEST

Cardiovascular disease/dyslipidemia

- Apo E Genotype Test (for type III hyperlipoproteinemia)

Cystic fibrosis

- Cystic Fibrosis DNA Test
 Reason for testing: Carrier screening Diagnostic
 Ethnicity: **REQUIRED**
 European Caucasian Asian Hispanic
 African American Ashkenazi Jewish Unknown
 Other (specify): _____

Fragile X syndrome and related testing

- Fragile X DNATest
 Fragile X DNA/Standard Chromosome Analysis Combined Test
 Fragile X Protein (FMRP) Test
 FRAXE DNATest
 FXTAS DNA Test (Fragile X-Associated Tremor/Ataxia Syndrome)

HLA-associated disorders

- Celiac Disease DNA Test Narcolepsy DNA Test
 HLA-B27 DNA Test

Hypercoagulability

- Factor V Leiden DNA Test Factor V R2 DNA Test
 Prothrombin (Factor II) DNA Test MTHFR DNA Test
 Factor V Leiden/Prothrombin (Factor II) Combined DNA Test
 Inherited Hypercoagulability Panel A (for patients not on Coumadin)
 Inherited Hypercoagulability Panel B (for patients on Coumadin)
 High Risk Pregnancy Hypercoagulability Panel
 Anti-β2 Glycoprotein-I Antibody (IgG, IgM, and IgA) Protein C Activity
 Anticardiolipin Antibodies (IgG, IgM, and IgA) Protein C/Factor IX Antigen Ratio
 Antiphospholipid Antibody Syndrome Panel Protein S Activity
 Antithrombin III Activity Protein S Antigen (free)
 Homocysteine Protein S Antigen (free and total)
 Lupus Anticoagulant Protein S/Factor IX Antigen Ratio Protein C Antigen

Iron overload

- Hemochromatosis DNA Test

Pharmacogenetics

- Warfarin DoseAdvise™ Genetic Test (CYP2C9 and VKORC1)
 Irinotecan DoseAdvise™ Genetic Test (UGT1A1)

Tay-Sachs disease

- Tay-Sachs Disease DNATest
 Reason for testing: Carrier screening Diagnostic
 Ethnicity: **REQUIRED** European Caucasian Ashkenazi Jewish
 Other (specify): _____
 Tay-Sachs Disease Enzyme Test

SPECIMEN Collection Date: _____

Sample Type:

- Blood Amniotic fluid
 Cheek cells Cultured amniocytes
 Citrated plasma (frozen) CVS
 Serum (frozen) Cultured CVS
 Other _____

PATIENT INFORMATION

Name _____
 Street Address _____
 City _____ State _____ Zip _____
 Phone # _____ Sex _____
 Date Of Birth _____ Patient ID# _____

INDICATION FOR TESTING

ICD-9 CODE(S)

(REQUIRED for billing Medicare or insurance)

Is this patient pregnant? yes no EDC _____
 Consent obtained? yes no

REQUESTER INFORMATION

Healthcare Professional _____
 Institution _____
 Street Address _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____

Healthcare Professional

Signature (required) _____

BILLING INFORMATION

Payment enclosed
 Bill to requesting institution
 Bill to insurance (please complete Insurance Billing section below)
 Bill to Medicare # _____ MD NPI# _____
 Bill to credit card
 Visa Mastercard American Express
 Account Number _____ Exp. Date _____
 Responsible Party _____ Telephone _____
 Street Address _____
 City _____ State _____ Zip _____
 Phone _____

INSURANCE BILLING

If LabCorp is to bill insurance, a copy of the insurance card (front and back sides of card) must be enclosed.

Patient relationship to insured _____

PATIENT AUTHORIZATION

I request payment of medical insurance benefits to LabCorp. I understand that I will be responsible for any portion of the claim that the insurance carrier does not pay.

 PATIENT SIGNATURE

 DATE