

PATIENT INFORMATION				ORDERING PROVIDER INFORMATION		
First name	MI	Last name	Preferred Name	Physician		
Date of birth	Genetic Sex (required): <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK		MRN #	Address		
Address		City		City	State	Zip Code
State	Zip code	Phone		Phone	Fax	
Ancestry (check all that apply)				NPI#		
<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Native American	<input type="checkbox"/> Ashkenazi Jewish		Additional Report To:		
<input type="checkbox"/> Black/AfricanAmerican	<input type="checkbox"/> Central/South American	<input type="checkbox"/> Middle Eastern				
<input type="checkbox"/> Hispanic	<input type="checkbox"/> West/North European	<input type="checkbox"/> Other				
<input type="checkbox"/> Asian	<input type="checkbox"/> East/Central European					

SAMPLE INFORMATION	
(Please check one) <input type="checkbox"/> Blood sample (Preferred) <input type="checkbox"/> Use stored extracted DNA <input type="checkbox"/> Saliva kit requested	<b>Does this individual have a history of:</b> <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Hematologic Malignancy <input type="checkbox"/> Bone Marrow Transplant <input type="checkbox"/> NONE If the answer is yes to any of these questions, please contact the laboratory to discuss before sending a sample.

STATEMENT OF MEDICAL NECESSITY (ONLY REQUIRED IF NO ELECTRONIC ORDER)	
ICD-10 Diagnoses Codes (REQUIRED) _____ _____ _____	I authorize and direct UPMC Clinical Genomics Laboratory (UCGL) to perform the testing indicated. I confirm that the testing requested is reasonable and medically necessary and that the test results may impact medical management and treatment decisions for this patient and participating family members. I certify that the patient or legal guardian and participating family members have been informed of the risks, benefits, and limitations of genetics testing. The person listed as the ordering provider is authorized by law to order the test(s) requested herein.  _____ Signature of Provider (Required) <span style="float: right;">Date</span>

PATIENT CONSENT (REQUIRED)		
By signing this form I acknowledge as the patient/legal guardian that I have read the informed consent document and that I authorize the UCGL to perform genetic testing.		
<input type="checkbox"/> OPT-IN: Please check this box if you wish to be recontacted for future research opportunities should they become available		
_____	_____	_____
Print name of Patient/Legal guardian	Signature of Patient/Legal Guardian	Date

PAYMENT OPTIONS: SELECT ONE			
<input type="checkbox"/> INSTITUTIONAL BILLING			
Facility	Address	Contact	Phone
			Email
<input type="checkbox"/> INSURANCE BILLING (copy front and back of insurance cards)			
Primary Insurance	Insurance ID#	Name and DOB of Insured	Patient Relation to Policy Holder
			Self Spouse Child
Secondary Insurance	Insurance ID#	Name and DOB of Insured	Prior Authorization # - Please Attach
<input type="checkbox"/> PATIENT BILLING			
<input type="checkbox"/> The patient is electing to self-pay and agrees that neither they nor UPMC Clinical Genomics Laboratory (UCGL) will submit a claim to their health insurance for testing.			

REQUISITION CONTINUES ON NEXT PAGE

