



PATIENT INFORMATION

(REQUIRED)

Last Name: _____ First Name: _____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Phone: _____ DOB: ____/____/____ SSN: _____ Gender: F M

INSURANCE INFORMATION

(REQUIRED)

Insurance Name: _____

Group#: _____ I.D#: _____

Bill Medicare Bill Medicaid Bill Patient

SPECIMEN INFORMATION

Date Collected: ____/____/____ Time Collected: _____

Fasting: Yes No Fax Results to: _____

ICD-10 CODES

It is the ordering party's responsibility to order only those tests medically necessary for the diagnosis and treatment of the patient.

A342 - Initial Wellness Profile (3SST, 1LT, 1LTP, 1GRP, 1RBL)

CBC w/DIFF Progesterone
Cortisol A.M. Renal Function Panel
DHEA-S Reverse T3, Serum
Estradiol SHBG
Ferritin T4 Total
Folate Testosterone, Free
FT3 Testosterone, Total
FT4 Total T3
GGT TSH
Heavy Metals 18 Uric Acid, Serum
Hemoglobin A1C Vitamins B1, B2, B3,
High Sensitivity CRP B5, B6, B12
Homocysteine Vitamin D 25-OH
Insulin Vitamin E, Serum
LDH Vitamin A, Serum
Lipid Profile Vitamin C

A343 - Follow Up Wellness Profile (3SST, 2LT, 1LTP, 1RBL)

CBC w/DIFF Lipid Profile
Cortisol A.M. Progesterone
DHEA-S Renal Function Panel
Estradiol Reverse T3, Serum
Ferritin SHBG
Folate T4 Total
FT3 Testosterone, Free
FT4 Testosterone, Total
GGT Total T3
Heavy Metals 18 TSH
Hemoglobin A1C Uric Acid, Serum
High Sensitivity CRP Vitamins B1, B2, B3,
Homocysteine B5, B6, B12
Insulin Vitamin D 25-OH
LDH

25D - PGx Comp Panel (1LT)

6300 - UTI Panel, PCR (1UC & 1GCT)

BLOOD ICD-10 CODES

- | | |
|---|--|
| <input type="checkbox"/> D50.9 Iron Deficiency Anemia, Unspecified | <input type="checkbox"/> E67.3 Hypervitaminosis D |
| <input type="checkbox"/> D51.9 Vitamin B12 Deficiency Anemia, Unspecified | <input type="checkbox"/> E72.11 Homocystinuria |
| <input type="checkbox"/> D52.8 Other Folate Deficiency Anemias | <input type="checkbox"/> E78.2 Mixed Hyperlipidemia |
| <input type="checkbox"/> D52.9 Folate Deficiency Anemia, Unspecified | <input type="checkbox"/> E78.49 Other Hyperlipidemia |
| <input type="checkbox"/> D64.2 Secondary Sideroblastic Anemia due to Drugs and Toxins | <input type="checkbox"/> E83.10 Disorder of Iron Metabolism, Unspecified |
| <input type="checkbox"/> E03.8 Other Specified Hypothyroidism | <input type="checkbox"/> G25.70 Drug Induced Movement Disorder, Unspecified |
| <input type="checkbox"/> E03.9 Hypothyroidism, Unspecified | <input type="checkbox"/> I10 Essential (Primary) Hypertension |
| <input type="checkbox"/> E11.9 Type 2 Diabetes Mellitus Without Complications | <input type="checkbox"/> K14.0 Glossitis |
| <input type="checkbox"/> E53.1 Pyridoxine Deficiency | <input type="checkbox"/> R73.09 Other Abnormal Glucose |
| <input type="checkbox"/> E53.8 Deficiency of Other Specified B Group Vitamins | <input type="checkbox"/> R78.89 Finding of Other Specified Substances, Not Normally Found in Blood |
| <input type="checkbox"/> E55.0 Rickets, Active | <input type="checkbox"/> R79.9 Abnormal Finding of Blood Chemistry, Unspecified |
| <input type="checkbox"/> E55.9 Vitamin D Deficiency, Unspecified | <input type="checkbox"/> Z79.899 Other Long Term (Current) Drug Therapy |
| <input type="checkbox"/> E67.2 Megavitamin-B6 Syndrome | |

PGX ICD-10 CODES

GROUP 1* (SELECT ALL THAT APPLY):	GROUP 2* (SELECT ALL THAT APPLY)
<input type="checkbox"/> F32.1 Major Depressive Disorder, Single Episode, Moderate	<input type="checkbox"/> E78.00 Pure Hypercholesterolemia, Unspecified
<input type="checkbox"/> F32.2 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features	<input type="checkbox"/> E78.01 Familial Hypercholesterolemia
<input type="checkbox"/> F32.3 Major Depressive Disorder, Single Episode, Severe With Psychotic Features	<input type="checkbox"/> E78.1 Pure Hyperglyceridemia
<input type="checkbox"/> F32.4 Major Depressive Disorder, Single Episode, In Partial Remission	<input type="checkbox"/> E78.2 Mixed Hyperlipidemia
<input type="checkbox"/> F32.9 Major Depressive Disorder, Single Episode, Unspecified	<input type="checkbox"/> E78.49 Other Hyperlipidemia
<input type="checkbox"/> F33.1 Major Depressive Disorder, Recurrent, Moderate	<input type="checkbox"/> I25.10 Atherosclerotic heart disease: Without hemodynamically significant stenosis
<input type="checkbox"/> F33.2 Major Depressive Disorder, Recurrent, Severe Without Psychotic Features	
<input type="checkbox"/> F33.3 Major Depressive Disorder, Recurrent, Severe With Psychotic Features	
<input type="checkbox"/> F33.41 Major Depressive Disorder, Recurrent, in Partial Remission	
<input type="checkbox"/> F33.9 Major Depressive Disorder, Recurrent, Unspecified	
<input type="checkbox"/> F41.1 Generalized Anxiety Disorder	

**Note: The provided ICD-10 codes are listed as a convenience. Ordering practitioners should report the diagnosis code that best describes the reason for performing the test, regardless of whether the code is listed above or not.*

UTI ICD-10 CODES

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> R30.0 Dysuria | <input type="checkbox"/> B37.41 Candidal cystitis & urethritis | <input type="checkbox"/> F03.90 Unspecified dementia, unspecified severity, w/o behavioral disturbance | <input type="checkbox"/> N56.01 Chlamydial cystitis & urethritis |
| <input type="checkbox"/> R30.9 Painful micturition, unspecified | <input type="checkbox"/> B37.49 Other urogenital candidiasis | | <input type="checkbox"/> N56.11 Chlamydial female pelvic inflammatory disease |
| <input type="checkbox"/> R36.0 Urethral discharge without blood | <input type="checkbox"/> N30.80 Other cystitis without hematuria | | <input type="checkbox"/> N73.9 Female pelvic inflammatory disease unspecified |
| <input type="checkbox"/> R36.9 Urethral discharge, unspecified | <input type="checkbox"/> N30.81 Other cystitis with hematuria | <input type="checkbox"/> R41.0 Disorientation, unspecified | <input type="checkbox"/> N39.0 Urinary Tract Infection, site not specified |
| <input type="checkbox"/> R82.71 Bacteriuria | <input type="checkbox"/> N34.1 Nonspecific urethritis | <input type="checkbox"/> R41.82 Altered mental status, unspecified | <input type="checkbox"/> N76.89 Other specified inflammation of vagina & vulva |
| <input type="checkbox"/> R82.79 Other abnormal findings on microbiological exam of urine | <input type="checkbox"/> N41.0 Acute prostatitis | | |
| <input type="checkbox"/> N45.1 Epididymitis | <input type="checkbox"/> N41.8 Other inflammatory diseases of prostate | <input type="checkbox"/> F41.9 Anxiety disorder, unspecified | |
| <input type="checkbox"/> N45.2 Orchitis | <input type="checkbox"/> N41.9 Inflammatory disease of prostate, unspecified | | |
| <input type="checkbox"/> N45.3 Epididymo-orchitis | | | |

Patient Acknowledgement and Authorization: I acknowledge that I have provided accurate and true information to the best of my knowledge. If I have provided my insurance information for direct insurance / 3rd party billing: I hereby authorize my insurance benefits to be paid directly to SMA Specialty Medical Lab (SMA) and authorize SMA to release medical information concerning my testing, including upon request my genetic testing results, to my insurer and any business associate of insurer (TB, TPA, etc.) I authorize SMA to be my Designated Representative for purposes of appealing any denial of health benefits. I understand that I am responsible for any amounts that my insurer determines are my responsibility after calculating deductibles, co-payments and co-insurance due under my policy. I consent to the use of my DNA for pharmacogenetic testing (see the back of this form). I understand that I am legally responsible for sending SMA Specialty Medical Lab any money received from my health insurance company for performance of this genetic test.

➤ PATIENTS SIGNATURE: _____ DATE: _____

Check One: Self Parent Legal Guardian Durable Power of Attorney for Health Care

Informed Consent and Medical Necessity: I affirm that I am legally authorized to order these tests OR that I am an authorized representative of a legally authorized provider to order these tests; and hereby order the tests requested above, which includes any sample collection device for testing. I hereby confirm that the test(s) are medically necessary for the treatment and/or plan of care for the patient, that the patient has read and understands the informed consent on the back of this requisition, and to the best of my knowledge, the information herein is accurate. I hereby confirm that the information has been supplied by SMA about genetic testing. The undersigned herein provided all the information and answered any questions regarding the informed consent.

Did the patient opt-out for the use of their sample for research purposes in the consent? Yes No

➤ PHYSICIAN SIGNATURE: _____ DATE: _____

SPECIMEN TYPE KEY

GRP = GREEN TOP PROTECTED FROM LIGHT
LTP = LAVENDER TOP PROTECTED FROM LIGHT
RBL = ROYAL BLUE TOP
GCT = GRAY CULTURE TUBE
SST = SERUM SEPARATOR
LT = LAVENDER TOP
UC = URINE CUP

Informed Consent for Pharmacogenetic Testing

Pharmacogenetic testing is used to help understand why some people respond better than others to certain medications and why some people develop side effects while others do not. SMA Specialty Medical Lab ("SMA") is authorized under Clinical Laboratory Improvement Amendments (CLIA) to perform high-complexity pharmacogenetic testing. The results are not intended to be used as the sole means for clinical diagnosis or patient management decisions. This pharmacogenetic test involves using your DNA, which can be found in your cells of blood or saliva, to examine your genetic make-up. In order to have your pharmacogenetic testing completed, the following is important information for you to know and understand:

- o You are having a sample of blood drawn or an oral specimen given to examine pharmacogenetic information which may help your provider understand how you may respond to different medications.
- o The Genetic Information Nondiscrimination Act (GINA) generally protects you against discrimination based on your genetic information when it comes to health insurance and employment.
- o Pharmacogenetic testing is available as a fee-for-service test. By signing this, you understand that you are responsible for what your insurance carrier does not pay. You will be responsible for payment after the testing has begun, even if you decide not to receive results.
- o Test results will include:
 - o your genotype, which is your personal genetic make-up;
 - o your phenotype, which is the functional meaning of your genetic make-up (e.g. "altered gene function", "fast-", "normal-", or "poor metabolizer").
 - o as a separate attachment, you will receive information compiled by another company on clinical consequences, drug dosing guidance, and potentially impacted medications. Depending on the ordering physician's selections, information on drug-drug interactions may be included in that attachment.

LIMITATIONS

Pharmacogenetic testing may yield uninterpretable results for the following reasons: 1) blood sample contamination, 2) insufficient sample collection, 3) incomplete knowledge of the available genetic markers, 4) technical reasons. This test does not account for all individual variations in the individual being tested. Absence of a detectable gene mutation does not rule out the possibility that a patient has different phenotypes due to the presence of an undetected polymorphism or due to other factors such as drug-drug interactions, comorbidities, and lifestyle habits.

GENETIC COUNSELING

It is recommended that you obtain pre-testing and post-testing counseling from someone professionally trained in genetics to consider the purpose, meaning, risks, benefits, and limitations of, as well as any alternatives to, genetic testing in your particular situation, including your personal and family medical history. Counseling may be provided by a genetic counselor (such as those found on the National Society of Genetic Counseling website), doctor and other qualified healthcare professional. Further testing or additional physician consults may be warranted.

PATIENT CONFIDENTIALITY AND TEST RESULTS DISCLOSURE

Your personal information and test results are confidential. While there can be no guarantee of privacy, SMA has established reasonable safeguards to protect it. Test results will only be released to the ordering healthcare professional, to those allowed access to test results by law, and to those whom you authorize in writing. By requesting payment by your insurance company, Medicare or other third-party payor, you specifically authorize the release of your Protected Health Information ("PHI"), including your lab test results, to such third-party payor or its authorized agents or representatives, as necessary for the purpose of determining coverage and facilitating payment.

I have discussed and understand the risks and benefits of this test. By signing this form, I authorize the use of my sample to obtain results for tests indicated above. Furthermore, I authorize SMA to retain, preserve, and use any data resulting from this test, as well as any leftover saliva, blood or DNA sample, for scientific or teaching purposes, or to dispose of at its convenience, unless initialed below.

Indicate your preference by checking one of the statements below:

- I do not wish for my specimen to be retained for Medical Research Purposes; discard within 60 days of collection.
- I agree to use of my de-identified biospecimen for medical research to improve genetic testing for all patients. I consent to my sample being retained beyond 60 days of collection; the retained sample will be de-identified by having all identifiers removed prior to re-testing. The de-identified sample and results obtained will remain anonymous.

Patient's Initials Here: _____