**Affix barcode label here**

###

###

### F: 954-533-8557 | P: 954-715-5040

### 4111 SW 47th Avenue, Unit 335, Davie, Florida 33314CLIA #: 10D2115383 | COLA #: 27267

**Pharmacogenomic Testing Requisition**

|  |
| --- |
|  **PATIENT INFORMATION \* (Asterisk Denotes Required Information) Don’t Cause Testing Delays - PRINT CLEARLY** |
|  First Name  |  Last Name  |  Middle Initial  |  Email Address |  |
|  SS #  |  D.O.B.  (mm/dd/yyyy) |  Phone |  Gender: 🞏Male 🞏Female 🞏Non-binary  |
|  Street Address/PO Box |  City  |  State |  Zip  |
| ANCESTRY/ETHNICITY: (Select all that apply) 🞏Ashkenazi Jewish 🞏Black/African American 🞏East Asian 🞏Hispanic 🞏Middle Eastern 🞏Native American 🞏South Asia 🞏White/Caucasian 🞏Unknown/Decline |
| **ORDERING PROVIDER\***   |
| Name:  |  Role/Title: | NPI#: |
| Street Address: |  City: |  State: |  Zip: |
| Telephone: |  Fax: | Email Address: |
| **PAYMENT OPTIONS\*** Billing (please select): 🞏Insurance 🞏Medicare 🞏Medicaid **\*** 🞏Self Pay/Other -*A Scion representative will contact you with payment options* |
| Primary Insurance Name: | Secondary insurance Name:  |
| Policy Holder Name | Relationship to Patient: 🞏 Self 🞏 Spouse 🞏 Parent | Policy Holder Name: | Relationship to Patient🞏 Self 🞏 Spouse 🞏 Parent |
| ID #:  | Group #: | ID #:  | Group #: |
| Effective Date: | Bin#: | Effective Date: | Bin#: |
| Claim Telephone number:  | Claim Telephone number: |
|  **ICD-10 DIAGNOSIS CODES\* - Please include applicable ICD-10 codes** Diagnosis and medical decision making are at the discretion of the patient care provider. |
|  |  |  |  |  |  |
|  **DELIVERY PREFERENCE FOR RESULTS REPORTING\*(Select one)** 🞏 Existing KIPU Account🞏 Scion Online Portal We set you up and email your login 🞏 Secure Email Ensure address is completed above 🞏 Other:  |
| **SAMPLE COLLECTION KIT SHIPPING INFORMATION\* -**  |
| Ordering provider to collect and ship sample  **Please Affix Bar Code Label Above****Date Sample Collected: (mm /dd /yy )**  |
| **OTHER PERSONAL INFORMATION –** Review and selectwhere appropriate. Laboratory personnel may contact you for more details. |
| 🞏 Allogenic Bone Marrow Transplant Recipient🞏 Diagnosis of a hematologic cancer with 20 years | 🞏 Patient has had a blood transfusion within the last 4 weeks 🞏 Previous pharmacogenetic testing (please include report) |  🞏 This patient is pregnant. Due Date is: (mm /dd /yy ) |
| **CURRENT MEDICATIONS –** List the patient’s current **medications and daily dosage-(**attach an additional page if more space is needed) |
|  |  |  |
|  |  |  |
| **PHARMACOGENOMIC TESTING REQUESTED\***- **Please select** ⌧ *Specimen Type: Buccal Swab*  |
| 🞏 **PGX FULL Panel** *APOE\*2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, F2, F5, MTHFR, SLCO1B1, VKORC1* | 🞏 **PGX Psychiatric Panel***CYP2C19, CYP2C9, CYP2D6, CYP3A4* | 🞏 **PGX Cardiac Panel** *APOE\*2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, SLCO1B1, VKORC1* | 🞎 **PGX Cardiac Panel + Thrombosis Genes** *APOE\*2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, SLCO1B1, VKORC1*plus*F2, F5, MTHFR* |
| **MEDICAL NECESSITY\*-** **Please select all that apply**  |
| **\***I attest that I am ordering this test to understand any possible risks or limitations associated with the specific medications currently prescribed or under consideration for this patient. This includes but is not limited to the following:  |
|  Potential associated adverse drug reactions  Efficacy of current or future drug therapy  |  Maximization of drug therapy that best matches this patient’s metabolic genotype/phenotype.  Validate current or future dosing will maximize therapeutic effect. Other: |
| **PROVIDER AUTHORIZATION\*** |
| *Providers should only order tests they deem medically necessary for the diagnosis and/or treatment of the patient. I authorize Scion Genomics to perform testing on specimen collected from my patients, as indicated by my preferences detailed above. I understand that this provider preferred order will remain in effect until an updated form has been submitted to Scion Genomics. I also understand that I may change these preferences, on a case-by-case basis, by designating my testing preferences on a requisition form.* |
| **PROVIDER NAME (PRINT) \*: X**  |  **PROVIDER SIGNATURE\*:**  **X**  | **DATE\*:**  **X**  |
| **Need more collection kits**? Order by calling 954-715-5040 Or order online at <http://scionlabservices.com/order.htm> |

**Date Sample Collected: (mm /dd /yy )**