Retrogen, Inc.
Solutions for Functional Genomics

PGx REQUISITION FORM

Patient Information

Name: _____
First MI Last

Date of Birth: _____ Age: _____ Sex: Unknown ☐ Female ☐ Male ☐
MM / DD / YYYY

Address: _____
Street Address Apt #

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Physician Identifier for Patient _____

Sample Specifications

Ship sample overnight at room temperature

Sample Collection Date: _____ Time: _____
MM / DD / YYYY AM ☐ PM ☐

Sample Drawn: Inpatient ☐ Outpatient ☐

Sample Type (Check Only One):

☐ Blood Sample (One > 2 mL whole blood in lavender-top EDTA Tube)

☐ Buccal Swab

☐ DNA (> 1µg at 50 ng/µL in TE preferred)

☐ Other (Please Specify): _____

All samples must have at least two identifiers

Referring Physician / Counselor Information

Institution Name: _____

Physician/Counselor: _____
First MI Last

Medical Specialty: _____

NPI#: _____

Genetic Counselor's Name: _____

Address: _____
Street address Building/Suite

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

e-mail: _____

Report Should be: Faxed ☐ E-mailed through a secure Server ☐

Physician/Counselor Statement:

I have explained DNA testing to this individual. I have addressed the limitations and benefits of testing and am witness to this patient's choice to have testing. I authorize this test.

_____ _____
Physician / Counselor Signature Date

Patient informed consent and Financial Acknowledgement

☐ I choose to have testing at this time ☐ I decline testing at this time

My signature below indicates that I have read (or had read to me) the information on the **second page** of this form pertaining to Patient Informed Consent and I understand this information.
I understand that I may have a financial responsibility associated with this testing, which is related to my insurance coverage and benefit plan and agree that I will make an effort to meet this financial obligation.

_____ _____
Signature of Patient / Parent or Legal Guardian of patient Date

Indications for Testing

1. ICD-9 Code (required for billing): _____
2. Patient: Historical or current exam findings:
3. Known family history of:
   ☐ _____
   ☐ _____
4. Laboratory or other relevant findings:
5. ☐ Check if patient has had a Bone Marrow Transplant (BMT)
6. Ethnic background:
   ☐ African American ☐ Ashkenazi Jewish ☐ Asian
   ☐ Caucasian ☐ Hispanic
   ☐ Other: _____
7. Is this a test for a known familial mutation: Yes ☐ No ☐

   Familial mutation : _____
   Gene (eg, MYH7) Variant (eg, c.746G>A)

   If Yes, was the family member (index patient) with the known mutation tested at Retrogen?

   ☐ No, Please attach a copy of the original index case report **(Required)**

   ☐ Yes, Please complete the following:

   Patient's relation to index patient: _____

   Index patient's name: _____
   First MI Last

   Index patient's date of birth: _____
   MM / DD / YYYY

   Accession #: _____

Index patient has approved release of information for purposes of this test

Retrogen, Inc. 6645 Nancy Ridge Dr. San Diego, CA 92121
(800) RETROGEN (858) 455-8411 www.retrogen.com
LAP Number: 8045555 - CLIA Number: 05D2049567

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Patient Informed Consent

By signing this form I understand that:

1. The purpose of this test is to look for genetic changes (called "variants" or "mutations") in one or more genes that are believed to be associated with the condition(s) specified above. Genetic testing may be used to confirm a diagnosis in a person who has an illness or may be used in individuals who have a family history of a genetic condition.
2. By signing this consent, I give my doctor permission to send my blood, DNA, tissue or other type of sample and medical records about me and/or my family history to Retrogen Diagnostics, Inc. I understand that this may help the laboratory to interpret the results of my test.
3. The methods used by Retrogen Diagnostics are highly accurate at detecting specific types of genetic changes. However, all genetic tests have limitations and a very rare possibility of error cannot be excluded. The testing used does not pick up every kind of change that is associated with disease. In addition, the test may uncover DNA changes that are not well-understood. In some cases, there is not enough information to determine if a change is associated with disease or if it is part of normal variation. In other cases, a change in a gene may be associated with a different condition than the one my doctor ordered the test for.
4. Retrogen has extensive information including specific statistics for each gene/condition for which its DNA testing is performed. These documents can be found on Retrogen's website: www.retrogen.com or my doctor may give me copies. Retrogen recommends that I read this information and discuss this test with my doctor or a specialist in genetics, such as a geneticist or genetic counselor.
5. DNA testing performed on multiple family members might uncover non-paternity (e.g. the test indicates that the acknowledged father is not the biological father) or other information about family relationships, such as adoption.
6. Retrogen will release the results of this test only to the ordering physician or to persons designated by me or my physician with my written permission, unless otherwise required by law.
7. Retrogen may contact my physician if new information affects the interpretation of previously reported test results. Retrogen will not contact another physician or individual without my written permission.
8. I understand that my sample will be securely stored in case re-testing is necessary. Samples are stored according to applicable Federal, State and professional regulations. If no regulation applies, samples will be stored according to lab policy and at the end of that time, the sample will be destroyed.

☐ **I do not want the laboratory to retain my sample for more than 60 days or after the testing ordered here has been completed.**

A. If additional testing is desired by myself or my doctor, my doctor is responsible for obtaining my informed consent and for sending a written request to Retrogen.
B. Retrogen may store my sample after the test is complete to use for research purposes. Prior to any research study, Retrogen will remove my name and any other identifying information from my sample and my clinical information. I understand that this may contribute to new inventions and that I will not receive any financial benefits from such developments.

☐ **I do not want my sample and clinical information to be used for research purposes**

9. My signature above indicates that I have read and understand this information and my questions have been answered. In cases when the patient is a minor or is otherwise unable to give consent, a parent, legal guardian or other legally authorized person should sign on the patient's behalf.

Test Selection

Select the desired test from the list found on Retrogen's web site: www.Retrogen.com.

Test #

☐ **9001 Pain Management Panel**
CYP2D6, CYP2C9, CYP2C19, CYP3A4, CYP3A5, CYP1A2, CYP2B6, OPRM1, COMT

☐ **9002 Cardiovascular Panel**
CYP2D6, CYP2C9, CYP2C19, VKORC1, SLCO1B1, CYP3A4, CYP3A5, MTHFR, Factor V Leiden, Factor II, APOE

☐ **9003 Psychotropic Panel**
CYP2D6, CYP2C9, CYP2C19, CYP3A4, CYP3A5, CYP1A2, OPRM1, COMT, DRD2

☐ **9004 Comprehensive Panel**
CYP1A2, CYP2B6, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, DRD2, APOE, COMT, Factor II, Factor V Leiden, MTHFR, OPRM1, SLCO1B1, VKORC1

Comments :

ID #
For Retrogen use Only

Retrogen, Inc.
Solutions for Functional Genomics

PGx REQUISITION FORM

BILL: ☐ INSTITUTION / CLIENT ☐ PATIENT ☐ INSURANCE

Institutional / Client Billing

Institution Name:

Department:

Billing contact:

Address:
Street address Building/Suite

City: State: Zip:

Phone: Fax:

e-mail:

Client Authorization #:

Patient Payment Responsibility

Credit card information and signature or payment by check or money order to cover patient co-payment and deductible is required for test processing or if the patient is uninsured.

Credit Card: ☐ MasterCard ☐ Visa ☐ Amex

Card number:

Expiration Date:

Name as it appears on card:

Address:
Street address Apt #

City: State: Zip:

Cardholder's Signature Date MM / DD / YYYY

Credit card payments are processed by Retrogen Diagnostics.

Check or Money Order:

☐ Enclosed in the amount of $

Commercial Insurance Billing

Commercial insurance does not include programs such as Medicare, Medicare HMOs, Medicaid, or Tricare/Champus

Please include a copy of both sides of the insurance card.

Subscriber's Name:

Relation to Patient:

Subscriber's date of birth:
MM / DD / YYYY

Primary Insurance:

Member ID#:

Group Policy#:

Pre-Auth#:

Claims:
Claims Mailing Address

City: State: Zip:

Phone:

Authorization to Release Information and Pay Benefits

I hereby authorize Retrogen Diagnostics, Inc. (Retrogen) to release all information necessary for reimbursement of my testing to my designated insurance carrier. I authorize that benefits under this claim be paid directly to Retrogen and will remit any insurance payments that I receive to Retrogen. I acknowledge responsibility for 100% of the service price if I fraudulently represent insurance. In the event of underpayment or denial by my insurance carrier, I authorize Retrogen or its designee to bill my secondary insurance carrier (if applicable) and/or attempt to over-turn denial of payment to receive reimbursement for the underpaid claim by the primary insurer.

Patient or Parent / Legal Guardian Signature Date MM / DD / YYYY

Please send samples and completed forms to:

Retrogen Diagnostics, Inc.
6645 Nancy Ridge Drive. San Diego. CA. 92121
Phone: 858-455-8411 Fax: 858-455-7987