Correlagen®

Requisition Form

Correlagen Diagnostics, Inc.
www.correlagen.com
Molecular Diagnostics for Genes that Matter™...

Patient Information

Name: ____
First name MI Last Name

Date of Birth: ____/____/_____ Sex: ☐ Male ☐ Female ☐ Unknown
mm dd yyyy

____
Address Apt #

____
City/State/Zip

Home Phone:____________________Work:____________________

Physician Identifier for Patient: ____________________

Referring Physician/Counselor Information

Institution Name:______________________________________

Name: ____
First MI Last

Medical Specialty:_______________________NPI#:___________

Genetic Counselor's Name:______________________________

____
Address Building/Suite

____
City/State/Zip

Phone:______________________Fax:______________________

Email: ____

Report should be: ☐ Faxed ☐ Emailed through 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

Test Selection (check all that apply)

Test	Options
PULMONOLOGY TESTING	
CYSTIC FIBROSIS	
☐ 160101 CFTR	
UROLOGY TESTING	
CONGENITAL BILATERAL ABSENCE OF VAS DEFERENS	
☐ 150101 CFTR	
NEPHROLOGY TESTING	
RENAL CYSTS AND DIABETES SYNDROME	
☐ 170201 TCF2	
VON HIPPEL-LINDAU DISEASE	
☐ 170101 VHL	
OPHTHALMOLOGY TESTING	
BARDET-BIEDL-SYNDROME	*Bardet-Biedl Syndrome:*
☐ 180199 BBS1, BBS2	☐ BBS1 ☐ BBS2
VON HIPPEL-LINDAU DISEASE	
☐ 180201 VHL	
GASTEROENTEROLOGY TESTING	
CHRONIC PANCREATITIS	*Pancreatitis:*
☐ 252794 CFTR, PRSS1, SPINK1	☐ CFTR ☐ PRSS1 ☐ SPINK1
METABOLIC	
GALACTOSEMIA	
☐ 252816 GALT	
WILSON'S DISEASE	
☐ 252803 ATP7B	
HEMATOLOGY	
BETA THALASSEMIA	
☐ 252823 HBB	
ONCOLOGY	
HNPCC	*HNPCC:*
☐ 252844 MLH1, MSH2	☐ MLH1 ☐ MSH2 ☐ MSH6 ☐ PMS2
☐ 252860 MLH1, MSH2, MSH6	
☐ 252863 MLH1, MSH2, MSH6, PMS2	

Please send sample and completed forms to:

Correlagen Diagnostics, Inc.
307 Waverley Oaks Road, Suite 101, Waltham, MA 02452
Phone: 866-647-0735 Fax: 781-647-0626

Sample Specifications

Ship sample overnight at room temperature

Sample Collection: _____/_____/_____ _____☐ A.M. _____☐ P.M.
mm dd yyyy

Sample Drawn: ☐ Inpatient ☐ Outpatient

Sample Type (Check One):

☐ Blood Sample (One ≥2 mL whole blood in lavender-top EDTA tube)

☐ DNA (≥ 1 µg at 50 ng/µl in TE preferred)

☐ Other: ______________________________
(Please contact client services before sending other sample types)

All samples must have a minimum of **two** identifiers.

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 Correlagen?
☐ 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 Name:____________________
Index Patient DOB: _____/_____/______Accession #:____________

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

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 Date

Cancellation requests will only be accepted if received before testing begins.

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Correlagen®

Payment Form

Correlagen Diagnostics, Inc.
www.correlagen.com
Molecular Diagnostics for Genes that Matter™…

Institutional / Client Billing

Institution Name:____
Department:____
Billing Contact:____

____
Address   Building/Suite

____
City/State/Zip

Phone:__________________________ Fax:_________________________
Email:____
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

☐ Master Card ☐ Visa ☐Amex Expiration Date: ______/______ (mm / yyyy)

Card Number: |__|__|__|__| |__|__|__|__| |__|__|__|__| |__|__|__|__|

Name as it appears on card:_____________________________________

____
Billing Address   Apt #

____
City/State/Zip

Cardholder Signature:__________________________Date:___________

Credit card payments are processed by Correlagen Diagnostics.

Check or Money Order

☐ Enclosed in the amount of $__________________________________

Commercial Insurance Billing

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

Primary Insurance:____
Subscriber Name:____
Subscriber DOB: ____/____/____ (mm dd yyyy) Relation to Patient:__________________
Member ID#:__________Group Policy #:_________Pre-Auth #:____________

____
Claims Mailing Address
________________________________Phone: _______________________
City/State/Zip

Secondary Insurance:____
Subscriber Name:____
Subscriber DOB: ____/____/____Relation to Patient:_________________
Member ID#:__________Group Policy #:__________Pre-Auth #:__________

____
Claims Mailing Address
________________________________Phone: _______________________
City/State/Zip

Authorization to Release Information and Pay Benefits

I hereby authorize Correlagen Diagnostics, Inc. (Correlagen) 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 Correlagen and will remit any insurance payments that I receive to Correlagen. 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 Correlagen 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

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 Correlagen Diagnostics, Inc. I understand that this may help the laboratory to interpret the results of my test.
3. The methods used by Correlagen 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. Correlagen has extensive information including specific statistics for each gene/condition for which its DNA testing is performed. These documents can be found on Correlagen’s website: www.correlagen.com or my doctor may give me copies. Correlagen 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. Correlagen 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. Correlagen may contact my physician if new information affects the interpretation of previously reported test results. Correlagen 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 Correlagen.

   B. Correlagen may store my sample after the test is complete to use for research purposes. Prior to any research study, Correlagen 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.

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