

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: _____

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)

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

Indications for Testing

1. ICD-9 Code (required for billing): _____
2. Test Patient: Historical or current exam findings :

3. Known family history of:

4. Laboratory or other relevant findings:

5. Ethnic Background:
 African American Ashkenazi Jewish Asian
 Caucasian Hispanic Other _____

Nephrology/Ophthalmology Test Selection (check all that apply)

NEPHROLOGY TESTING

RENAL CYSTS AND DIABETES SYNDROME

170201 TCF2

VON HIPPEL-LINDAU DISEASE

170101 VHL

OPHTHALMOLOGY TESTING

BARDET-BIEDL-SYNDROME

180199 BBS1, BBS2

Bardet-Biedl Syndrome:

BBS1 BBS2

VON HIPPEL-LINDAU DISEASE

180201 VHL

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 effort to meet this financial obligation.

Signature of Patient/Parent or Legal Guardian

Date

6. 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

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.

