ApolloGen
13766 Alton Parkway, Suite 147
Irvine, CA 92618
Phone: (949) 916-8886
Fax: (949) 916-8899
inquiries@apollogen.com
www.apollogen.com

General Test Requisition Form

Patient Information

Patient Last Name: ________________________________

Patient First Name: ________________________________

Date of Birth (MM/DD/YY): __________________________

Sex: ☐Male ☐Female ☐Unknown

Guardian Name (if minors): _____________________________

Address: ____

City: ____________________________ State: _____ Zip: __________

Phone: ____

E-mail: ____

Ethnic Background:

☐African American ☐Native American ☐Caucasian ☐Hispanic

☐Mediterranean ☐Middle Eastern ☐Asian/Pacific Islander

Referring Provider Information

Name (Last, First, MI.): _______________________________________

Address: ____

City: ____________________________ State: _______ Zip: _________

Phone: _____________________ Fax: ___________________________

E-mail: ____

Physician Signature: ____

Genetic Counselor: ____

Preferred Method of reporting: ☐Email ☐Fax ☐Mail ☐Phone

Additional Results Recipient

Name (Last, First, M.): ____

Phone: _____________________ Fax: ___________________________

Email: ____

Specimen Information

Date/Time of Sample Collection: ______________________________

Date/Time of Sample Received (at facility): ______________________

Sample Type: ☐Whole Blood ☐Saliva

Clinical Indication: ____

____

ICD 10 Codes: ____

Please check all of the following situations that apply:

☐ Patient has had transfusion within the past 30 days

☐ Patient has had bone marrow transplant

☐ Patient or family member is pregnant

Informed Consent and Statement of Medical Necessity

I have supplied information to the patient regarding genetic testing and the patient has given consent for genetic testing to be performed. I further confirm that this test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder, and the results will be used in the medical management and treatment decisions for the patient. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test(s) requested herein.

Physician Signature: _________________________Date: ___________

Test Menu

Please select the test(s) you would like to order:

2001 ☐ BRCA1 and BRCA2 Sequencing Panel

2002 ☐ Breast Cancer Panel

2004 ☐ Colorectal Cancer Panel

9000 ☐ iGene Personal Health and Disease Risk Panel (Cancer + Cardiac + Pharmacogenomics)

- 9001 ☐ iGene Cancer Panel (Selected High Risk Hereditary cancers)
- 9002 ☐ iGene Cardiac Panel (Selected Cardiomyopathy, cardiac conduction disease genes)
- 9003 ☐ iGene Pharmacogenomics Panel

3000 ☐ Comprehensive Cardiomyopathy Panel

3001 ☐ Dilated Cardiomyopathy Panel

3002 ☐ Hypertrophic Cardiomyopathy Panel

4000 ☐ Familial Hypercholesterolemia Panel

8100 ☐ Comprehensive Mitochondrial Genome Analysis

ApolloGen
13766 Alton Parkway, Suite 147
Irvine, CA 92618
Phone: (949) 916-8886
Fax: (949) 916-8899
inquiries@apollogen.com
www.apollogen.com

Billing Information

Please select one and fill in the appropriate information:

☐ Insurance Billing (include copy of both sides of insurance card)

Name of Insured: ______________________________

Insured Patient's Address: ______________________________

Insured Patient's Phone Number: ______________________________

Insured Patient's or Guardian's SSN: ______________________________

Insurance Company: ______________________________

Member ID: ______________________________

Group #: ______________________________

Authorization #: ______________________________

Authorization Date: ______________________________

Billing Address: ______________________________

City: ______________ State: __________ Zip: __________

Insurance Phone: ______________________________

Email: ______________________________

*ApolloGen recommends submitting a patient-specific letter of medical necessity (LMN), as most insurance carriers will require one for processing (a LMN is not required for Medicare patients that meet medical guidelines).

☐ Institutional Billing

Referring Physician: ______________________________

Institution: ______________________________

Billing Address: ______________________________

City: ______________ State: __________ Zip: __________

Phone: ______________________________

Email: ______________________________

☐ Patient Self-Pay Options

☐ Cash ☐ Check ☐ Money Order

Please make all checks payable to:
ApolloGen, Inc.

☐ Card Payment

☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Cardholder Printed Name: ______________________________

Cardholder Signature: ______________________________

Card Number: ______________________________

CVC #: ____________ Exp. Date: ______________

Amount $: ____________ Date: ______________

Billing Address: ______________________________

City: ______________ State: ______ Zip: __________

Cardholder Phone: ______________________________

Cardholder Email: ______________________________

Please sign below after reading the following acknowledgement:

Patient Acknowledgement for Financial Responsibility

I acknowledge that the information provided by me is true to the best of my knowledge. For direct insurance or third party billing, I hereby authorize my insurance benefits to be paid directly to ApolloGen, Inc. and authorize them to release medical information concerning my testing to my insurer. I understand that I am financially responsible for any amounts not covered by my insurer for this test order.

I also fully understand that I am legally responsible for sending ApolloGen any money received from my health insurance company for the performance of this genetic test. Failing to do so will result in my account being sent to collection.

Patient Signature: ______________________________

Date: ______________________________

ApolloGen
13766 Alton Parkway, Suite 147
Irvine, CA 92618
Phone: (949) 916-8886
Fax: (949) 916-8899
inquiries@apollogen.com
www.apollogen.com

Specimen & Shipment Information

Please select a sample type:

☐ Whole Blood

Infants (<2 years): 2-3 mL
Children (>2 years): 3-5 mL
Older Children & Adults: 6-9 mL

EDTA/Lavender top tubes

Blood samples should be sent by overnight shipping at room temperature as soon as possible after being drawn. If the specimen cannot be sent immediately, it should be stored refrigerated at 4°C. The blood specimen must not be stored for more than 3 days at 4°C.

☐ Saliva

Saliva samples should be collected with an Norgen Saliva DNA Collection Kit following the manufacturer's instructions.
Please contact us for a kit at (949)-916-8886 if necessary.

☐ DNA

Average amount is 10 micrograms collected in Tris buffer or H_2O. The sample(s) should be stored at -20°C, and shipped on ice or at room temperature.

Please ship all samples to:

ApolloGen Clinical Laboratory
13766 Alton Parkway, Suite 147
Irvine, CA 92618, USA.

Ship all samples by overnight courier or mail.

Do not ship on Fridays.

Samples may be received Monday-Friday, 8am-5pm. Call to alert the laboratory of pending shipment(s), or email the tracking number to us.

Phone: (949) 916-8886
Email: inquiries@apollogen.com

ApolloGen is closed on weekends and observes the following holidays. If shipping a sample during these times, please contact the company prior to sample collection.

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

ApolloGen
13766 Alton Parkway, Suite 147
Irvine, CA 92618
Phone: (949) 916-8886
Fax: (949) 916-8899
inquiries@apollogen.com
www.apollogen.com

Clinical and Family History

Patient's Name: ______________________________ Date of Birth: ____________________

Maternal Ethnicity: ____________________________ Paternal Ethnicity: ____________________________

Consanguinity: Are the parents of the patient related to each other by blood (e.g. second cousins)? ☐ Yes ☐ No

If so, how are they related: ____

Please describe the patient's symptoms and family history using the checklist below as a guideline. You may attach a pedigree if available:____

____

____

Please describe previously abnormal tests – e.g. Metabolic tests, MRI, Echocardiograms, Tumor Pathology, or other functional studies:

____

____

Cancer - Does anyone in the family have:

Patient (present and/or past)

☐ Cancer (please describe type of cancer, and age of onset): ____

____

Family (present and/or past)

☐ Cancer (please describe how this family member is related to you, type of cancer, and age of onset if known):______________________

____

____

Cardiovascular disease/symptoms - Does anyone in the family have:

Patient	Family		Patient	Family		Patient	Family	
☐	☐	Chest pains	☐	☐	Shortness of breath	☐	☐	Irregular Heart beat
☐	☐	Cardiomyopathy	☐	☐	Heart murmur	☐	☐	Stroke
☐	☐	Coronary Heart Disease	☐	☐	Hypertension	☐	☐	Other ___________

General health concerns – Is there anyone in the family with:

Patient	Family		Patient	Family		Patient	Family	
☐	☐	Diabetes (adult or juvenile)	☐	☐	Kidney Problems	☐	☐	Psychiatric Disorders
☐	☐	Sudden Deaths	☐	☐	Genetic Diseases	☐	☐	Abnormal Skin Findings
☐	☐	Neurological/Muscular Problems	☐	☐	Eye Problems	☐	☐	Blood Disorders
☐	☐	Chronic infections	☐	☐	Multiple miscarriages (≥3) or infertility			

☐ ☐ Any other condition not listed here (please describe):____