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

Mitochondrial Testing 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): _____

☐ Blood (EDTA tube) ☐ Skin Fibroblast Culture

☐ Cord Blood ☐ Stem Cell Culture

☐ Saliva ☐ Liver ☐ Tissue

☐ Extracted DNA ☐ Skeletal Muscle

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:

Mitochondria -related Clinical Tests

8100 ☐ Comprehensive Mitochondrial Genome Analysis

8300 ☐ Mitochondrial Nuclear Gene Panel

8400 ☐ Mitochondrial Depletion Syndrome Panel

8500 ☐ All-inclusive Mitochondrial Disorders Panel
(Mitochondrial nuclear gene panel + Mitochondrial Genome)

9999 ☐ Other _____

Mitochondria -related Research Tests

8101 ☐ Mitochondrial DNA Analysis for Cell Authentication TR

8102 ☐ Mitochondrial DNA Analysis for Cell Authentication DR

8103 ☐ iPSC Mitochondrial DNA Analysis with Table Report (TR)

8104 ☐ iPSC Mitochondrial DNA Analysis with Detailed Report (DR)

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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:_____

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Clinical Indication and 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: _____

Indication of Testing:

☐ Symptomatic with a known clinical diagnosis ☐ Asymptomatic

☐ Symptomatic with suspicion of a form of mitochondrial disorder ☐ Other _____

Please describe previously abnormal tests (patient or the affected family member) e.g. metabolic, imaging, or other functional studies:

_____

Please describe the patient's symptoms or family history (if patient is asymptomatic) using the checklist below as a guideline. You may attach a pedigree if available:

Central Nervous System
- ☐ Developmental Delay/ID/MR
- ☐ Dementia
- ☐ Hypotonia
- ☐ Headaches/Migraines
- ☐ Neuro-psychiatric disturbances
- ☐ Autistic Features
- ☐ Seizures
- ☐ Atypical cerebral palsy
- ☐ Strokes

Nerves
- ☐ Weakness (may be intermittent)
- ☐ Peripheral Neuropathy
- ☐ Neuropathic pain
- ☐ Fainting
- ☐ Dysautonomia
- ☐ Absent reflexes
- ☐ Temperature instability

Muscle
- ☐ Muscle weakness
- ☐ Cramping
- ☐ Gastrointestinal problems
- ☐ Irritable bowl syndrome
- ☐ Diarrhea or constipation
- ☐ Cycling vomiting
- ☐ Pseudo-obstruction
- ☐ GERD
- ☐ Hypotonia
- ☐ Dysmotility

Renal
- ☐ Renal tubular acidosis or wasting

Cardiac
- ☐ Cardiac conduction defects (heart blocks)
- ☐ Arrhythmia
- ☐ Cardiomyopathy

Metabolites and Liver
- ☐ Liver failure
- ☐ Hepatomegaly/Enlarged Liver
- ☐ Hypoglycemia
- ☐ Lactic Acidosis
- ☐ Abnormal metabolic tests

_____

_____

Ears & Eyes
- ☐ Visual loss and blindness
- ☐ Ptosis
- ☐ Optic atrophy
- ☐ Ophthalmoplegia
- ☐ Acquired strabismus
- ☐ Retinitis pigmentosa
- ☐ Hearing loss
- ☐ Deafness

Endocrine
- ☐ Diabetes
- ☐ Exocrine Pancreatic failure
- ☐ Hypothyroidism
- ☐ Parathyroid failure
- ☐ Short stature

Systemic
- ☐ Failure to gain weight
- ☐ Unexplained vomiting
- ☐ Fatigue
- ☐ Respiratory problems
- ☐ Recurrent pregnancy loss/infertility

Miscellaneous
- ☐ Known Genetic Diseases
- ☐ Known Familial Mutation
- ☐ Evidence of Maternal Inheritance
- ☐ Other; Please describe any other condition not listed here_____

_____

_____