ApolloGen
15375 Barranca Pkwy, A105-106, Irvine, CA 92618
Phone: (949) 916-8886| Fax: (949) 916-8899
inquiries@apollogen.com
www.apollogen.com

CARDIOLOGY TEST REQUISITION FORM

PATIENT INFORMATION

Patient Last Name: _____ Patient First Name: _____ MI_____

Date of Birth (MM/DD/YY): _____ Sex: ☐ Male ☐ Female ☐ Unknown

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____E-mail: _____

Ethnic Background (check all that apply)

☐ African American ☐ Asian/Pacific Islander

☐ Caucasian ☐ Hispanic ☐ Mediterranean

☐ Native American ☐ Other_____

REFERRING PHYSICIAN INFORMATION

Name (Last, First, MI.): _____ Provider NPI#_____ Institution Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____E-mail: _____

Genetic Counselor/Additional Recipient:_____Phone/Fax/Email:_____

Preferred Method of reporting: ☐ Website Portal ☐ Fax ☐ Mail ☐ Phone

Location ID:

SAMPLE INFORMATION

Date Collected: _____

Date Received: _____ (Lab Use Only)

Collected By: _____ Volume: _____

Sample Type: ☐ Blood (EDTA purple-top tube) ☐ Saliva ☐ DNA

CLINICAL INFORMATION

Clinical Indications: _____

_____

ICD-10 codes: _____

_____

Please check all of the following situations that apply:

☐ Patient has had bone marrow transplant

☐ Patient has had transfusion within the past 30 days

☐ Patient or immediate family member is pregnant

BILLING INFORMATION

☐ **INSTITUTIONAL BILLING** Institution Name and Contact: _____

☐ **MEDICARE/MEDICAID** Medicare/Medicaid No. _____State: _____

☐ **INSURANCE BILLING** *Please include a copy of insurance card(s) both front and back for billing purposes*

Policyholder Name _____ DOB (MM/DD/YY) _____ Phone Number_____

Insurance Co. _____ Member ID _____ Group No. _____

☐ **SELF PAYMENT** (Invoice for payment will be issued upon receipt of sample. Please completely fill out patient's address to avoid delay of testing.)

Patient Acknowledgement for Financial Responsibility

I acknowledge that the information provided by me is true to the best of my knowledge. 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's Name: _____ Patient's Signature:_____ Date:_____

STATEMENT OF MEDICAL NECESSITY

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's Name: _____ Physician's Signature:_____ Date:_____

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TEST REQUESTED

Cardiomyopathy Panels

- ☐ 3001 Dilated Cardiomyopathy Panel (33 genes)
- ☐ 3003 Comprehensive Cardiomyopathy Panel (44 genes)
- ☐ 3002 Hypertrophic Cardiomyopathy Panel (18 genes)

Arrhythmia Panels

- ☐ 3021 Arrhythmias Panel (101 genes)
- ☐ 3031 Long QT Syndrome Panel (20 genes)
- ☐ 3025 Atrial Fibrillation Panel (47 genes)
- ☐ 3045 Sudden Death Syndrome Panel (68 genes)

Aortopathy and Aneurysm Panels

- ☐ 3035 Marfan Syndrome and Thoracic Aortic Aneurysm and Dissection Panel (17 genes)
- ☐ 3055 Connective Tissue Disorder Panel (39 genes)

Familial Hypercholestrolemia

- ☐ 3050 Familial Hypercholesterolemia Panel (4 genes)

Pulmonary Hypertension

- ☐ 3041 Pulmonary Hypertension Panel (9 genes)

Comprehensive Cardiovascular Panels

- ☐ 3015 Cardiomyopathy and Arrhythmia Panel (101 genes)
- ☐ 9002 iGene Cardiac Panel (23 gene focus panel)
- ☐ 3011 Pan-Cardio Panel (410 genes)
- ☐ 1500 Clinical Focused Exome (6110 genes)

Other Cardiovascular Testing Options

- ☐ 1100 Comprehensive Pharmacogenomics (PGx) Panel
- ☐ 1130 Cardiovascular Health PGx Panel
- ☐ 1140 Thrombophilia Panel

CLINICAL AND FAMILY HISTORY (Clinical Note Must Be Attached)

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: _____

Previous genetic testing (of patient's or family members'):

Test:_____ Result:_____

Test:_____ Result:_____

Previous Clinical Testing or studies – e.g. Metabolic tests, Echocardiograms, EKG and etc.

Test:_____ Result:_____

Test:_____ Result:_____

Test:_____ Result:_____

Patient's Clinical Symptoms:

- ☐ Aortic/ Arterial Aneurysm
- ☐ Aortic/ Arterial Dissection
- ☐ Arrhythmia
- ☐ Cardiomyopathy
- ☐ Congenital Heart Defects
- ☐ Coronary Heart Disease
- ☐ Dilated Aortic Root
- ☐ Embolism/Thrombosis
- ☐ FHx of Sudden Cardiac Death
- ☐ High LDL-C level _____
- ☐ Hypermobility
- ☐ Hypertension
- ☐ Pulmonary Hypertension
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Syncope
- ☐ Other Features _____

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CARDIOLOGY TEST REQUISITION FORM

CLINICAL AND FAMILY HISTORY (Continued)		
Family History of Cardiovascular Diseases/Symptoms (or attach pedigree if available):		
Relationship	Symptoms/Diagnosis	Age of Diagnosis/Onset
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPECIMEN COLLECTION AND SHIPPING INFORMATION		
Whole Blood	Collection	3-5 mL of whole blood in EDTA (purple-top/lavender-top) for routine tests.
	Shipping	Send 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 for no more than 5 days.
Saliva	Collection	At least 2 mL of saliva sample should be collected with a Norgen Saliva DNA Collection Kit following the manufacturer's instructions. IMPORTANT: No eating, drinking, smoking or chewing gum 30 minutes prior to collection. Kit is available upon request.
	Shipping	Ship overnight at room temperature If the specimen cannot be sent immediately, it should be stored at room temperature.
Extracted DNA	Collection	Send at least 10ug of extracted DNA (minimal concentration 25ng/ul)
	Shipping	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze

- Please sterile technique for specimen collection and close all containers tightly. DO NOT FREEZE OR ADD FIXATIVE TO ANY SAMPLE.
- Please clearly label all containers with at least two patient identifiers (patient's name and date of birth), along with the collection date. Secure each specimen container tightly to avoid leakage in transit.
- Complete the test requisition with the patient's demographics and insurance information, including diagnosis/ICD-10 codes.
- Samples may be received Monday-Friday, 8am-5pm. Call to alert the laboratory of pending shipment(s), or email the tracking number to us at inquiries@apollogen.com.
- Delivery address: ApolloGen Clinical Laboratory
  13766 Alton Parkway, Suite 147
  Irvine, CA 92618, USA.
- Please contact us for instructions for other specimen type and additional shipping materials at 949-916-8886.

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CARDIOLOGY TEST REQUISITION FORM

INFORMED CONSENT FOR CARDIAC GENETIC TESTING

First Name: _____ Last Name: _____

DOB (MM/DD/YYYY): _____

I understand that my health care provider has ordered the following genetic testing for {me/my child}:

_____

This is a voluntary test to identify gene mutation associated with inherited cardiovascular diseases and you may wish to seek genetic counseling prior to signing this form. Read this form carefully before making your decision about testing.

PURPOSE

I am interested in obtaining a genetic test by submitting a biological sample of my own (blood, saliva, or other tissue). The purpose of this molecular genetic test is to ascertain if I am or my child is carrying mutation(s) predisposing to or causing inherited cardiovascular diseases. The biological sample submitted is required for isolation and purification of DNA and molecular genetic testing by next generation sequence analysis of genes associated with cardiovascular disorders.

THE FOLLOWING POINTS WERE EXPLAINED AND I UNDERSTAND THAT:

1. Due to the complexity of DNA based testing and the implications of the results, these results will be reported only through my designated physician(s) or genetic counselor (where allowed) and that I must contact my provider to obtain the results of the test. The test results, in addition, could be released to all who, by law, may have access to such data.
2. DNA-based studies performed are specific to the condition indicated above. The results should be evaluated in the context of personal and family health history, the results of physical examination, laboratory and hospital test, and clinical impression of my healthcare provider. I understand that possible result outcomes include positive, negative, and uncertain.
3. If results of the tests are uncertain (in the case of variants of unknown clinical significance), meaning that there is not enough information to determine whether this change is associated with an increased risk for cardiovascular disease after thorough search of current literature and databases.
4. Unexpected results may be revealed from this test in rare instances. This test is designed to detect changes in genes that predispose a person to cardiac disease; however, it can uncover genetic conditions in a family unrelated to cardiovascular diseases, including early-onset Alzheimer's disease, Barth syndrome, Duchenne muscular dystrophy, etc. Results also have the potential to reveal unexpected biological relationships, such as a different biological parent.
5. It is the responsibility of the referring physician or health care provider to understand the specific utility and limitations of the testing ordered, and to educate the patient regarding these limitations. While this test is designed to identify most detectable mutations in the genes analyzed, it is still possible there are mutations that this testing technology is unable to detect. In addition, there may be other genes associated with cardiovascular disease susceptibility that are not included on this panel or that are not known at this time.
6. The molecular genetic test occasionally may not generate results and that an additional blood, saliva, or tissue sample may be needed to obtain interpretable results.
7. Inaccurate results, though rare, may occur for the following reasons: sample mix-up, samples unavailable from critical family members, maternal contamination of prenatal samples, inaccurate reporting of family relationships, or technical problems, but not limited to these.
8. The genetic tests results have implications for blood relatives. In consultation with an appropriate healthcare provider, I may wish to discuss sharing the test results with certain blood relatives who may be at risk.

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CARDIOLOGY TEST REQUISITION FORM

USE OF SPECIMENS FOR RESEARCH

After testing is completed, I understand that my blood, saliva, or tissue specimens may be disposed of or retained indefinitely for de-identified research, test validation, and/or education as long as my privacy is maintained. I understand that no compensation will be given for using the specimens submitted. I understand that I may refuse to submit my specimen for use in this way and may withdraw my consent at any time by contacting the laboratory. I understand that my refusal to consent to medical research will not affect my results. Indicate consent or denial below. If neither box is marked, consent is implied.

Consent to the use of my sample for anonymous research:

☐ Yes ☐ No

RECOMMENDATIONS

I understand that due to the dynamics of medical genetics field, there continues to be new information and data. It is recommended that I keep in contact with my healthcare provider, annually, to learn of any new developments in cardiology genetics and to provide any updates to my personal or family history which may affect my cardiovascular disease risks.

PATIENT CONSENT STATEMENT

By signing below, I, the patient having the test performed, acknowledge that:

I have read or have had read to me all of the above statements and understand the information above and have had the opportunity to ask questions. I understand the procedure, the risks, benefits, limitations and the alternatives associated with this test. I can request a copy of this consent form.

Patient Name:_____Date:_____

Patient Signature: _____