ApolloGen
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Phone: (949) 916-8886| Fax: (949) 916-8899
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www.apollogen.com

GENERAL GENETIC 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

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 No. _____

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

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 CATALOGUE

Cancer Panels

- ☐ 2001 BRCA1 and BRCA2 Sequencing Panel (2 genes)
- ☐ 2005 Breast Cancer and Gynecologic Cancer Core Panel (14 genes)
- ☐ 2021 Colorectal Cancer Core Panel (12 genes)
- ☐ 9001 iGene Cancer Panel (25 genes)

Personal Health Risk Panels

- ☐ 9001 iGene Cancer Panel (25 genes)
- ☐ 9002 iGene Cardiac Panel (23 genes)
- ☐ 3050 Familial Hypercholesterolemia
- ☐ 1140 Thrombophilia Panel
- ☐ 1210 Comprehensive Obesity and Diabetes Panel
- ☐ 1213 Overweight and Obesity Panel
- ☐ 1216 Diabetes and Prediabetes Panel
- ☐ 1220 Comprehensive Obesity and Diabetes Panel + Obesity/Diabetes Related PGX
- ☐ 8700 Vital Mito (Mitochondrial Copy Number Analysis)

Pharmacogenomic Testing Options

- ☐ 1100 Comprehensive Pharmacogenomics (PGX) Panel
- ☐ 1110 Pain Management PGX Panel
- ☐ 1120 Mental Health PGx Panel
- ☐ 1130 Cardiovascular Health PGx Panel

Other Tests

- ☐ 1500 Clinical Focused Exome (6110 genes)
- ☐ 8100 Comprehensive Mitochondrial Genome Analysis

CLINICAL AND FAMILY HISTORY (Clinical Note Must Be Attached)

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

Test:_____ Result:_____

Test:_____ Result:_____

Clinical Symptoms of patient or family members:

Patient /Family member i.e. Father	Symptoms/Diagnosis (please specify age of diagnosis after each diagnosis)

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INFORMED CONSENT FOR 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 hereditary disease and health risks 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 disease or elevated health risks. 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 hereditary health risks.

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 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 a certain health condition; however, it can sometimes uncover genetic conditions in a family unrelated to the targeted disease risks. 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 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.

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

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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 medical genetics and to provide any updates to my personal or family history which may affect my disease susceptibility 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: _____