

Orthopedic Test Requisition

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.



| PRIMARY PATIENT | | | |
|-------------------------------|--|------------------------------------|---------|
| LAST NAME | | FIRST NAME | |
| DATE OF BIRTH (MM/DD/YYYY) | | GENETIC SEX Male Female Unknown | |
| MED REC#/PATIENT IDENTIFIER | | ETHNICITY | |
| ADDRESS | | | |
| CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY |
| PHONE | | EMAIL | |
| SAMPLE DRAW DATE (MM/DD/YYYY) | SAMPLE TYPE Blood Bucal Other Extracted DNA & DNA Source: (Blood, Bucal, Tissue, Fibroblast) | | |

I have read the Informed Consent document and I give permission to Claro Lab to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Claro lab and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at www.Clarolaboratory.com/policies/privacy-policy.

Opt out of research

Check this box if you are a New York state resident and give permission for Claro lab to retain any remaining sample longer than 60 days after the completion of testing.

| | |
|---|-------------------|
| PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES) X | DATE (MM/DD/YYYY) |
|---|-------------------|

| ORDER PROVIDER | | | |
|---------------------------|----------------|------------------------------------|---------|
| INSTITUTION/PRACTICE NAME | | INSTITUTION PHONE/FAX/EMAIL | |
| PROVIDER LAST NAME | | PROVIDER FIRST NAME | |
| NPI (USA) | MINC (CANADA) | PROVIDER TITLE (MD, DO, GC) | |
| PROVIDER ADDRESS | | | |
| CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY |
| PROVIDER PHONE | | FAX REPORT TO | |
| GC/PRIMARY CONTACT | | GC/PRIMARY CONTACT PHONE/EMAIL/FAX | |

I attest that the patient has received and read the Claro Lab Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Claro Lab Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

| | |
|--|-------------------|
| ORDERING PROVIDER SIGNATURE (REQUIRED) X | DATE (MM/DD/YYYY) |
|--|-------------------|

INSURANCE BILLING

Attach front and back of all insurance cards, ABN, medical criteria form

| | | | | |
|---|-----------------|-------------------|---------------------|--|
| PLEASE ATTACH INSURANCE CARDS FOR BILLING | | ICD-10 VALID CODE | REFERRAL/PRIOR AUTH | By signing above, the patient or insured authorizes Claro Lab Genetics to release medical information concerning the test to the assigned insurance company. |
| PRIMARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE # |
| INSURANCE PLAN | NAME OF INSURED | | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY) |
| SECONDARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE # |
| INSURANCE PLAN | NAME OF INSURED | | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY) |

INSTITUTIONAL BILLING

SELF PAY

| | | | |
|---------------------------|----------------|-------------|---------|
| INSTITUTION/PRACTICE NAME | | | |
| ATTENTION TO | | | |
| ADDRESS | | | |
| CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY |
| PHONE | FAX/EMAIL | | |

| | | | |
|--|----------------|---|---------|
| Use patient information above for billing Use information below for billing | | By signing above, the patient or payor authorizes Claro Lab to contact them directly, and use the provided billing instructions to bill the indicated method. | |
| PAYOR LAST NAME | | PAYOR FIRST NAME | |
| ADDRESS | | | |
| CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY |
| PHONE | FAX/EMAIL | | |

If I am covered by insurance, I authorize CLARO LABS and their contracted billing company to give my insurance carrier the information on this form and provided by my healthcare provider that is necessary for reimbursement. I understand that I am responsible for deductible and coinsurance amounts as indicated by my insurance carrier. I agree to assist in resolving insurance claim issue ans if I do not assist, I may be responsible for the sill cost of the test. I understand that I am responsible for sending CLARO LABS any and all of the money that I receive directly from my insurance carrier in payment for this test.

If the test is not authorized by or is not covered by my insurance, than I will be contacted with the option to either cancel the ordered test or elect to pay out-of-pocket according to the proposed payment plan provided to me when I am contacted. IF I elect to pay out-of-pocket, I will be responsible for all payment obligations arising from the ordered testing and guarantee payment for these services. I understand that if payments or arrangements are not made after 3 statements my information may be sent to collections.

Claro Labs is committed to support you with your share of costs. If required, you will be contacted by our team to setup a payment plan for your portion of the costs using the following forms of payment: Check, Visa, Master Card. You may also contact our billing team at 518-702-4353.

| | |
|---|-------------------|
| PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES) X | DATE (MM/DD/YYYY) |
|---|-------------------|

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| CLINICAL HISTORY | | Attach any available detailed medical records and clinical notes | | | | | | | | | |
|---|---|---|------------------------|-----------------------------|----------------------------|---------------------------|----------------------|---|-----------------------|--|---|
| Clinical Details | | | | | | | | | | | |
| <p>Check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;">Mosacism</td> <td style="width:33%;">Bone Marrow Transplant</td> <td style="width:33%;">Known Chromosomal Gain/Loss</td> </tr> <tr> <td>Consanguinity</td> <td>Organ Transplant</td> <td>Known Gene Gain/Loss</td> </tr> </table> <p>Please specify any that are checked above</p> | | Mosacism | Bone Marrow Transplant | Known Chromosomal Gain/Loss | Consanguinity | Organ Transplant | Known Gene Gain/Loss | <p>There are many factors which may affect genetic diagnostic testing: such as gene-gene interactions, high risk ethnicity groups, and transplants. Please list any that may apply. For additional details, please see the Claro Lab website.</p> | | | |
| Mosacism | Bone Marrow Transplant | Known Chromosomal Gain/Loss | | | | | | | | | |
| Consanguinity | Organ Transplant | Known Gene Gain/Loss | | | | | | | | | |
| Clinical Presentation | | | | | | | | | | | |
| <p>Please indicate any clinical presentations and/or findings that may be relevant to genetic testing:</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%;">- Behavior</td> <td style="width:50%;">- Phenotypes</td> </tr> <tr> <td>- Conditions</td> <td>- Physical</td> </tr> <tr> <td>- Pedigree/Family History</td> <td>- Symptoms</td> </tr> </table> | | - Behavior | - Phenotypes | - Conditions | - Physical | - Pedigree/Family History | - Symptoms | <p>There are many presentations which may not seem like a direct association for disease. Please list the most suspected presentations and attach detailed medical records and/or pedigree.</p> | | | |
| - Behavior | - Phenotypes | | | | | | | | | | |
| - Conditions | - Physical | | | | | | | | | | |
| - Pedigree/Family History | - Symptoms | | | | | | | | | | |
| Clinical Testing | | | | | | | | | | | |
| <p>Please indicate any clinical testing results and/or findings that may be relevant to genetic testing:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;">- Karyotype</td> <td style="width:33%;">- Hearing</td> <td style="width:33%;">- Imaging</td> </tr> <tr> <td>- Previous Genetic Testing</td> <td>- Growth Measurements</td> <td>- Pathology Reports</td> </tr> <tr> <td>- Vision</td> <td>- Biochemical Testing</td> <td></td> </tr> </table> | | - Karyotype | - Hearing | - Imaging | - Previous Genetic Testing | - Growth Measurements | - Pathology Reports | - Vision | - Biochemical Testing | | <p>Please also include tests that had a negative result. These tests help our clinical staff process the results of your testing.</p> |
| - Karyotype | - Hearing | - Imaging | | | | | | | | | |
| - Previous Genetic Testing | - Growth Measurements | - Pathology Reports | | | | | | | | | |
| - Vision | - Biochemical Testing | | | | | | | | | | |
| FAMILY HISTORY | | Attach pedigree and additional pages as needed | | | | | | | | | |
| FAMILY MEMBER 1 NAME | RELATION TO PATIENT | <table style="width:100%; border: none;"> <tr> <th colspan="3" style="text-align: left; font-size: small;">GENETIC SEX</th> </tr> <tr> <td style="width:33%; text-align: center; font-size: x-small;">Male</td> <td style="width:33%; text-align: center; font-size: x-small;">Female</td> <td style="width:33%; text-align: center; font-size: x-small;">Unknown</td> </tr> </table> | GENETIC SEX | | | Male | Female | Unknown | | | |
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| Male | Female | Unknown | | | | | | | | | |
| DIAGNOSIS AND/OR SYMPTOMS | | <table style="width:100%; border: none;"> <tr> <th style="width:50%; font-size: small;">AGE OF ONSET</th> <th style="width:50%; font-size: small;">DOB (MM/DD/YYYY)</th> </tr> <tr> <td style="height: 20px;"></td> <td></td> </tr> </table> | AGE OF ONSET | DOB (MM/DD/YYYY) | | | | | | | |
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| | | | | | | | | | | | |
| FAMILY MEMBER 2 NAME | RELATION TO PATIENT | <table style="width:100%; border: none;"> <tr> <th colspan="3" style="text-align: left; font-size: small;">GENETIC SEX</th> </tr> <tr> <td style="width:33%; text-align: center; font-size: x-small;">Male</td> <td style="width:33%; text-align: center; font-size: x-small;">Female</td> <td style="width:33%; text-align: center; font-size: x-small;">Unknown</td> </tr> </table> | GENETIC SEX | | | Male | Female | Unknown | | | |
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| | | | | | | | | | | | |
| FAMILY MEMBER 3 NAME | RELATION TO PATIENT | <table style="width:100%; border: none;"> <tr> <th colspan="3" style="text-align: left; font-size: small;">GENETIC SEX</th> </tr> <tr> <td style="width:33%; text-align: center; font-size: x-small;">Male</td> <td style="width:33%; text-align: center; font-size: x-small;">Female</td> <td style="width:33%; text-align: center; font-size: x-small;">Unknown</td> </tr> </table> | GENETIC SEX | | | Male | Female | Unknown | | | |
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| | | | | | | | | | | | |
| TEST REQUESTED – <i>Select only one test</i> | | | | | | | | | | | |
| <p style="text-align: center;"><u>Osteogenesis Imperfecta NGS</u></p> <p>BMP1, COL1A1, COL1A2, CRTAP, FKBP10, IFITM5, P3H1, PPIB, SERPINF1, SERPINH1, SP7, SPARC, TMEM38B, WNT1 (14 Genes)</p> | <p style="text-align: center;"><u>Orthopedic Panel</u></p> <p>Streptococcus Canis Serratia Marcescens Pseudomonas Aeruginosa</p> | | | | | | | | | | |
| <p style="text-align: center;"><u>Osteogenesis Imperfecta and Decreased Bone Density NGS</u></p> <p>ALPL, ANO5, B4GALT7, BMP1, CLCN5, COL1A1, COL1A2, CRTAP, DMP1, ENPP1, FGF23, FKBP10, GNAS, GORAB, IFITM5, LMNA, LRP5, MAFB, MMP2, NOTCH2, P3H1, PHEX, PLOD2, PPIB, SERPINF1, SERPINH1, SLC34A3, SP7, SPARC, TMEM38B, TNFRSF11A, WNT1(32 Genes)</p> | | | | | | | | | | | |

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INSTRUCTIONS

1. Complete the patient and provider information section.
2. Read and sign the informed consent policy statement. The complete patient informed consent form for genetic testing can be found on Clarolaboratory.com. Signature from the provider on Page 1 of the TRF is required for all testing . Signature from the patient is only required for billing purposes.
3. Write in the test name and indicate any relevant test options. Please call us if you have any questions.
4. Add-on any additional genes. Visit our website for our most updated list of 18,000+ available genes.
5. For Duo/Trio testing, please complete the Family Samples section or submit a separate TRF for each sample .
6. Please visit Clarolaboratory.com for specimen requirements.

Extracted DNA must be extracted from a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by CAP and/or CMS.

INSTRUCTIONS

- Detailed medical record (pedigree if available)
- ICD-10 codes(s)
- Physician, patient, and insured signatures
- Copy of insurance card(s) - front/back
- Insurer specific forms (i.e. ABN)
- Insurance authorization, if available
- For Medicare, Medicare criteria form is required

For the most updated information and limitations on our products and services, please visit Clarolaboratory.com