tesis biosciences

A CLIA Accredited Laboratory
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PLACE 1 BARCODE ON FORM AND 1 ON SAMPLE (REQUIRED: NAME/DOB)

CHECKLIST:
☐ Demographics/Medication List ☐ ICD-10 Codes ☐ ABN (Medicare)
☐ Physician & Patient Signatures ☐ Copy of Patient Insurance Card

Diabetes Test Requisition Form

First Name | *Last Name* | *Middle Initial* | Clinic Name

Social Security # | *Date of Birth* | *Sex* ☐ F ☐ M | *Ethnicity* ☐ African American ☐ Asian ☐ Ashkenazi Jewish ☐ Caucasian ☐ Hispanic ☐ Other

Address | *City* | *State* | *Zip* | *Phone*

INSURANCE: *Please provide a legible copy of the front and back of the patient's insurance card.* IF NO INSURANCE: ☐ Self Pay ☐ WC/Auto (Date of Injury) ☐ Other

Name of Insured | *Relationship to Patient* | *Insurance Company/Provider* | *Member/ID Number* | *Group Number*

Collector Name (Print) | *Date Collected* | *Time Collected* | *Fasting* ☐ Yes ☐ No

Specimen Type
☐ 0CD-100 (Buccal)

Specimen Storage
☐ Room Temperature ☐ Refrigerated

Specimen Shipping
☐ Room Temperature ☐ Cooling/Ice Pack

MOLECULAR DIAGNOSTICS TESTING OPTIONS

Diabetes Genomics Test *Please select the Panel to be tested. Please attach patient Medication List.*

☐ Diabetes - Obesity Comprehensive NGS

ADRB2, PPARG, CEL, KCNJ11, MC4R, BBS10, HNF1B, INS, PDX1, HNF1A, BBS1, BBS2, GCK, HNF4A, LEPR, ABCC8, CEP290, ADRB3, AGRP, ALMS1, ARL6, BBS12, BBS4, BBS5, BBS7, BBS9, BDNF, CARTPT, EIF2AK3, ENPP1, FOXP3, GHRL, GLIS3, GNAS, LEP, MAGEL2, MKKS, MKS1, NEUROD1, NEUROG3, NTRK2, PCSK1, POMC, PPARGC1B, PTF1A, PYY, RFX6, SDC3, SDCCAG8, SIM1, TRIM32, TTC8, UCP1, UCP3, WDPCP, WFS1 (56 Genes)

☐ MODY Neonatal Diabetes NGS

KCNJ11, PDX1, INS, HNF1A, HNF1B, GCK, HNF4A, GLUD1, ABCC8, AKT2, APPL1, BLK, CEL, CISD2, CP, EIF2AK3, FOXP3, GATA6, GLIS3, HADH, IER3IP1, INSR, KLF11, NEUROD1, NEUROG3, PAX4, PTF1A, RFX6, SLC2A2, WFS1, ZFP57 (31 Genes)

Diabetes Personal/Family History Questionnaire *Please complete Questionnaire*

PATIENT'S PERSONAL HISTORY (Hx)

Clinical Details	Personal Hx	Age at Dx
Mosaicism	☐ Yes ☐ No	
Consanguinity	☐ Yes ☐ No	
Bone Marrow Transplant	☐ Yes ☐ No	
Organ Transplant	☐ Yes ☐ No	
Known Chromosomal Gain/Loss	☐ Yes ☐ No	
Known Gene Gain/Loss	☐ Yes ☐ No	

FAMILY HISTORY

Relationship	Maternal	Paternal	Cancer Site(s)	Age at Dx
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

Clinical Presentation *Please indicate any clinical presentations and/or findings that may be relevant to genetic testing:*

☐ Behavior ☐ Conditions ☐ Pedigree/Family History
☐ Phenotypes ☐ Physical ☐ Symptoms

Clinical Testing *Please indicate any clinical testing results and/or findings that may be relevant to genetic testing:*

☐ Karyotype ☐ Vision ☐ Growth Measurements ☐ Imaging
☐ Previous Genetic Testing ☐ Hearing ☐ Biochemical Testing ☐ Pathology Results

ICD-10 DIAGNOSIS CODES: *Additional documentation supporting Medical Necessity may be attached.*

☐ I11.0 Hypertensive heart disease with heart failure
☐ Z13.1 Encounter for screening for diabetes mellitus
☐ R73.09 Other abnormal glucose
☐ R73.01 Impaired fasting glucose
☐ R73.02 Imparied glucouse tolerance (oral)
☐ R73.9 Hyperglycemia, unsp
☐ E66.01 Morbid Obesity due to excess calories
☐ E66.09 Other obesity due to excess of calories
☐ E66.8 Other obesity
☐ E66.9 Obesity, unsp
☐ E66.3 Overweight
☐ Z68.3X Body mass indexes 30.0-39.9 (adult)
☐ Z68.4x Body mass indexes > 40.0 (adult)
☐ R63.1 Polydisia
☐ R53.83 Fatigue or Weakness
☐ R06.02 Shortness of breath
☐ R11.0 Nausea
☐ R11.10 Vomiting
☐ R82.4 Acetonuria- High levels of Ketones in the urine
☐ R73.9 Hyperglycemia, unsp
☐ R19.6 Halitosis - Fruity-scented breath
☐ R35.0 Frequency of Micturition
☐ R68.2 Dry mounth, unsp
☐ L85.3 Xerosis cutis
☐ R41.0 Confusion
☐ R10.0 Acute Abdomen
☐ R23.2 Flushing face
☐ Other _____

Medical Necessity *Required for insurance*
☐ I, the provider, attest that I am the ordering physician or am authorized under applicable laws and regulations to order genetic testing for the patient. I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder, and that the results will be used in medical management and care decisions for the patient. I further attest that any information entered on this Test Requisition Form, or otherwise provided by me on behalf of the patient, is true and correct to the best of my knowledge, and that the patient has consented to receive communications about his/her genetic test from RDL.

Patient Informed Consent *Patient must consent*
☐ I, the patient, voluntarily consent to the collection and testing of my specimen. I certify that the specimen is fresh and has not been adulterated in any manner. I authorize the laboratory to release the results of this testing to the ordering provider. I further authorize my insurance benefits to be paid directly toRDL for services rendered. I acknowledge that the lab may be treated as an out-of network provider. In the event I receive payment for laboratory services from my insurer, I will remit said payment to the lab within 14 days of receipt. I will either endorse the original check, or produce a personal check for the entire payment amount, and forward it to the lab. When selecting Self Pay above, I acknowledge financial responsibility for all lab charges associated with the processing of this test requisition. All rights to the samples will belong to the laboratory conducting the testing. There will be no compensation in the event of an invention resulting from research and development using this sample. I agree to allow my provided specimen to be used for the purpose of (diagnosis/research) (development/quality control). I understand that if I agree, any information identifying me will be kept confidential so that it will not be possible to determine from whom the sample was drawn.
Your signature on this form indicates that you understand to your satisfaction the information about RDL and agree to have the test done. In no way does this waive your legal rights or release anyone from their legal and professional responsibilities. If you have further questions concerning matters related to this consent, you may wish to seek professional genetic counseling prior to signing this form. Consultation with a medical geneticist, genetic counselor, or your referring healthcare provider also may be warranted after the test has been completed.

Opt In for Research
☐ I give permission for my specimen and clinical information to be used in de-identified studies at Tesis Biosciences and for publication, if Tesis deems it appropriate. I understand that my name and/or other identifying information will NOT be used in or linked to the results of any studies and publications. More information is available at www.tesisbiosciences.com.

Provider Name (Print)	*Provider NPI #*	*Clinic Address*	*Clinic Phone/Fax*
Provider Signature X	*Date*	*Patient Signature (or Legal Guardian)* X	*Date*