tesis biosciences

A CLIA Accredited Laboratory
(844) 837-4780 | info@tesisbiosciences.com

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

Immunodeficiency 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	Specimen Storage	Specimen Shipping
☐ 0CD-100 (Buccal)	☐ Room Temperature ☐ Refrigerated	☐ Room Temperature ☐ Cooling/Ice Pack

MOLECULAR DIAGNOSTICS TESTING OPTIONS

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

☐ Comprehensive Primary Immunodeficiency

BLM, BRCA2, CFTR, F9, F5, FANCC, G6PD, G6PC, JAK2, MSH6, MYD88, PALB2, NRAS, PMS2, PLCG2, PTEN, RUNX1, MPL, TERT (19 genes)

Family History

If Yes, describe below and attach clinical notes. ☐ Yes ☐ No

Indications for Testing. Check all that apply.

☐ Diagnostic ☐ Family History ☐ Positive or normal control

☐ Other .....

Will Patient management be changed depending on the test results? ☐ Yes ☐ No

FAMILY HISTORY

Relationship	Maternal	Paternal	Diagnosed Condition(s)	Age at Dx
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

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

☐ D84.821 Immundeficiency due to drugs
☐ D84.822 Immundeficiency due to external causes
☐ D84.81 Immundeficiency due to conditions classified elsewhere
☐ D84.89 Other immunodeficiencies
☐ L03.011 Cellulitis of right finger
☐ M32.9 Systemic lupus erythematosus
☐ Z79.899 Other long-term (current) drug therapy
☐ C90.00 Multiple myeloma not having achieved remission
☐ T45.1x5a Adverse effect of antineoplastic and immunosuppresive drugs, initial encounter
☐ D89.9 Disorder involving the immune mechanism, unspecified
☐ B20 "Human immunodeficiency virus [HIV]disease"
☐ I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease
☐ B59 Pneumocystosis
☐ C80.2 Malignant neoplasm associated with transplanted organ
☐ C88.8 Other malignant immunoproliferative diseases
☐ C94.40 Acute panmyelosis with myelofibrosis not having achieved remission
☐ C94.41 Acute panmyelosis with myelofibrosis, in remissio
☐ C94.42 Acute panmyelosis with myelofibrosis, in relaps
☐ C94.6 Myelodysplastic disease, not classified
☐ D46.22 Refractory anemia with excess of blasts 2
☐ D47.1 Chronic myeloproliferative disease
☐ D47.9 Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified
☐ D70.4 Cyclic neutropenia
☐ D71 Functional disorders ofpolymorphonuclear
☐ D72.0 Genetic anomalies ofleukocytes
☐ D72.810 Lymphocytopenia
☐ D72.818 Other decreased white blood cell count
☐ D73.81 Neutropenic splenomegaly
☐ D75.81 Myelofibrosis
☐ D76.1 Hemophagocytic lymphohistiocytosis
☐ 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	***Date***	***Patient Signature (or Legal Guardian)***	***Date***
X		**X**	