



**TARGETED VARIANT TEST REQUISITION FORM**

Please print clearly and provide all requested information. CTGT cannot initiate testing unless this information is provided.

PATIENT / SPECIMEN INFORMATION					
PATIENT NAME – LAST, FIRST, MI		<input type="checkbox"/> M <input type="checkbox"/> F	MRN		DATE OF BIRTH (MM-DD-YYYY)
ADDRESS			PHONE		ETHNICITY
CITY, STATE, ZIP			NAME OF LEGAL GUARDIAN IF PATIENT IS A MINOR		
TYPE OF SPECIMEN		DATE OF COLLECTION		DATE AND TIME OF RECEIPT (TO BE COMPLETED BY CTGT)	
REPORTING INFORMATION					
REFERRAL SOURCE					
REFERRED BY		NPI NUMBER		GENETIC COUNSELOR	
INSTITUTION			PHONE		FAX
ADDRESS			E-MAIL		
CITY, STATE, ZIP			<b>SIGNATURE (REQUIRED – By signing, you agree to the Terms on page 10 of this form)</b>		
ADDITIONAL REPORTS					
REFERRING LAB			CONTACT PERSON		
ADDRESS			PHONE		FAX
CITY, STATE, ZIP			REFERRING LAB ID#		
PAYMENT INFORMATION					
<input type="checkbox"/> <b>INSTITUTIONAL BILLING</b>					
FACILITY NAME			CONTACT PERSON		
ADDRESS			PHONE		FAX
CITY, STATE, ZIP			E-MAIL		
<input type="checkbox"/> <b>SELF PAY (ALSO REQUIRED FOR ALL INSURANCE CASES – PLEASE SEE “INSURANCE” BELOW.)</b>					
<input type="checkbox"/> CHECK <input type="checkbox"/> M.O.		Please make check or money order payable to <b>Health Network Laboratories.</b>		CARD HOLDER NAME	
<input type="checkbox"/> MC <input type="checkbox"/> VISA		ACCOUNT NUMBER		BILLING ZIP CODE	
The total cost of testing is \$_____.			EXPIRATION DATE		3 DIGIT SECURITY CODE (on back of card)
I agree that CTGT, LLC. shall bill this amount to my credit card.				<b>SIGNATURE OF CARDHOLDER (REQUIRED)</b>	
<input type="checkbox"/> <b>INSURANCE - Important note to Patients:</b> CTGT does not participate with any health plan, and CANNOT guarantee that your plan will reimburse you or CTGT for our testing services. By choosing Insurance Billing, <b>you agree that CTGT will charge the account listed in the Self Pay section above BEFORE testing will be initiated.</b> You may then seek reimbursement from your insurance company by selecting one of the following options:					
<input type="checkbox"/> Send copy of invoice to Patient at the address provided in the Patient information section above. Patient will submit a claim to insurance company.					
<input type="checkbox"/> Submit invoice to my insurance provider on my behalf. Any funds collected by CTGT will be forwarded to the Patient at the address provided above.					
In addition to completing the information below, be sure to provide a clear copy of both the front and back of your insurance card, and sign below.					
NAME OF INSURED			RELATIONSHIP TO PATIENT		
INSURANCE ID NUMBER			GROUP NUMBER		
PRE-AUTHORIZATION NUMBER		DATE(S) AUTHORIZATION VALID		INSURANCE COMPANY PHONE NUMBER	
<b>SIGNATURE OF INSURED (REQUIRED)</b>					
PLEASE CONTACT OUR OFFICE PRIOR TO SENDING SPECIMEN IF THERE ARE ANY QUESTIONS.					

Patient Name: _____	Patient DOB: _____
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Prenatal testing:  Yes  No    Anticipated delivery date: \_\_\_\_\_  Female  Male

1389: Maternal cell contamination testing (*recommended for all prenatal testing*)

Has karyotyping been performed?  Yes  No \_\_\_\_\_

TARGETED VARIANT TESTING	FAMILY HISTORY																									
Individual to be tested:  <input type="checkbox"/> Affected/Symptomatic <input type="checkbox"/> Unaffected/Asymptomatic	Is there a family history of disease for which the patient is being tested? <input type="checkbox"/> Yes <input type="checkbox"/> No																									
Proband Name: _____ Proband DOB: _____ Proband Case #: _____ Relationship to Proband: _____  <input type="checkbox"/> 1387 One Mutation <input type="checkbox"/> 2027 Three Mutations <input type="checkbox"/> 1388 Two Mutations <input type="checkbox"/> 2044 CNV Mutation <span style="margin-left: 150px;">Deletion/Duplication Analysis</span>  Gene/Mutation: _____	<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width:20%;">Relationship to the individual being tested</th> <th style="width:10%;">Maternal</th> <th style="width:10%;">Paternal</th> <th style="width:10%;">DX</th> <th style="width:10%;">Age at DX</th> </tr> </thead> <tbody> <tr><td> </td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td> </td><td> </td></tr> <tr><td> </td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td> </td><td> </td></tr> <tr><td> </td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td> </td><td> </td></tr> <tr><td> </td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td> </td><td> </td></tr> </tbody> </table>	Relationship to the individual being tested	Maternal	Paternal	DX	Age at DX		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>		
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**MEDICAL RECORDS**

Clinical history for this individual is required for variant reclassification. Please include relevant clinical notes and other medical records or provide a brief description of the individual's clinical features in this box. If the patient has no relevant clinical features, please indicate in this box.

**OTHER NOTES**

**TERMS OF SERVICES**

The contracted price for any tests on the requisition form applies to that test only. Included in the contract price is the service of answering any question regarding test results. Additional charges apply to parental or familial testing. Additional charges may apply to any future requests relating to this test.

CTGT is not responsible for obtaining or submitting blood, tissue or other samples from patients for testing, nor is it responsible for communicating test results to patients. CTGT, therefore, assumes no liability for: Any injury or illness incurred from obtaining a blood sample, biopsy or other specimen. Mislabeling or misidentification of submitted samples. Incorrect or incomplete information provided in test requisition forms. Information provided to CTGT outside of its requisition forms or order process. Any loss incurred as a result of communicating the outcome of any genetic tests to patients or their representatives. CTGT further disclaims any liability for incorrect or incomplete information in any written or verbal communication other than test results reports prepared by CTGT, including, but not limited to, its web site, brochures, technical information, emails, letters or telephone conversations. **IN NO EVENT SHALL CTGT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, CONSEQUENTIAL OR PUNITIVE DAMAGES ARISING OUT OF ANY USE OF OR INABILITY TO USE CTGT'S SERVICES, WHETHER BASED ON WARRANTY, CONTRACT, TORT OR ANY OTHER LEGAL THEORY, REGARDLESS OF WHETHER CTGT IS ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.**