Molecular Vision Laboratory Requisition Form

www.mvisionlab.com

3375 SW Terwilliger Blvd, Portland, OR 97239 |Phone 503 418-2535 | Fax 503 494-6261 | Requisition@mvisionlab.com

Patient Information

Last Name:

First Name: **M.I.**

DOB: **Patient ID/Med Rec #:**

Address:

City: **State/Pr:** **Zip:**

Preferred Phone:

Gender: Male Female Unknown

Parent name (if patient is a minor)**:**

Race/Ethnicity of patient (check all that apply):

African-American Asian Caucasian/NW European
E. Indian Hispanic Jewish-Ashkenazi Jewish-Sephardic
Native American Native Hawaiian/Other Pacific Islander
Other

Ordering Provider

Name:

Institution (if applicable):

Address:

City: **State/Pr:** **Zip:**

Phone:

Email: **required for international clients**

Please fax result to:

Genetic Counselor

Name:

Phone: **Email:**

Please fax result to:

Referring Hospital or Laboratory (if applicable)

Name:

Address:

City: **State/Pr:** **Zip:**

Phone:

Email:

Please fax result to:

Specimen Information

Date/Time Collected:

Sample Type

Blood Serum Plasma DNA
Amniotic Fluid POC Chorionic Villi
Saliva Dried Blood Spot Other

Test Requested

Gene/Disease Name:*

Testing for known familial mutation:

Mutation:

Name/ID of relative: Relationship:

If expedited testing is requested, please indicate reason:

Pregnancy Gestational Age (weeks)

Other Reason:

Gene/Panel:
Price:

Gene/Panel:
Price:

Gene/Panel:
Price:

Gene/Panel:
Price:

Gene/Panel:
Price:

Genetic testing prices are the same for all forms of payments.

Current test list and pricing information can be found by visiting www.mvisionlab.com

Molecular Vision Laboratory Payment Form

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Family History

Please provide relevant information below including the names or ID# of any relatives previously tested.

Reason for Testing

Indication: ☐ Diagnostic ☐ Carrier ☐ Prenatal ☐ Presymptomatic ☐ Other

ClinicalDiagnosis:

Molecular Vision Lab Internal Use Only:

Date Received:

Case #:

Institutional Billing Information:

Accounts are charged upon receipt. You will receive an invoice/statement monthly. Payment is expected within 90 days.

PO#/Dept. Code:

Hospital/Lab Name:

Contact Name:

Address:

City: State: Zip:

Phone: Fax:

Institutional Billing Stamp

See next page for self pay or insurance billing...

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Payment By Credit Card

The full amount of the test fee is due prior to service being rendered.International orders must be made in US Funds.

Name (as it appears on card):

Billing Address:

City: State: Zip:

Phone:

☐ Mastercard ☐ Visa ☐ American Express ☐ Discover

Account #:

Please bill my credit card in the amount of $

Security Code: Expiration Date:

for diagnostic laboratory tests performed by Molecular Vision Laboratory.

Signature (required)

Insurance Billing

(Must also complete credit card information)

Molecular Vision Laboratory cannot bill Medicare or Medicaid.

We will bill health plans only if proof of coverage for genetic testing and copies of front and back of insurance card are provided.

I UNDERSTAND THAT I AM RESPONSIBLE IN ALL CASES FOR ALL FEES NOT COVERED BY INSURANCE.

Signature (required)

Genetic testing prices are the same for all forms of payment.

ICD9 Code:

The ICD9 symptoms or known diagnosis code is provided by the referring physician or laboratory.

Payment by Check or Money Order

The full amount of the test fee is due prior to service being rendered. International orders must be made in US Funds.

Check or money order enclosed in the amount of $

☐ **Referring lab/provider has obtained genetic testing informed consent from patient.** (Please send copies of signed consent with specimen).