Molecular Vision Laboratory Requisition Form

www.mvisionlab.com

1920 NE Stucki Ave. Ste. 150, Hillsboro, OR 97006 | P: 503-227-3179 | F: 503-227-3157 | inquiry@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

www.mvisionlab.com

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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

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)

Must provide the following:

1. **Insurance confirmation of genetic testing coverage and approval**
2. **Copies of back and front of insurance card**

By signing, you confirm that you are responsible in all cases for fees not covered by insurance.

Signature (required)

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).

Molecular Vision Laboratory, Inc.

CO1400

MVL

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

I, _____ **voluntarily** request the Molecular Vision Laborary, Inc to perform DNA-based testing for (condition) myself _____ in and/or my child.

_____

Child's Name (Last, First, MI) Child's (DOB) (MM/DD/YY) Gender (M/F)

The following points have been explained to me:

1. DNA testing is performed on biological samples, which will be collected using standard techniques. I understand that there may be risks associated with obtaining my sample. Additional samples may be needed if the specimen is damaged in shipment or inaccurately submitted.

2. DNA testing may detect an abnormality, called a mutation, in a gene and this may indicate that I, or the individual being tested, may have, or may develop the specific disease/condition being tested for. In other cases, DNA testing is unable to identify an abnormality although an abnormality may still exist. This event may be due to current lack of knowledge of the complete gene structure or an inability of the current technology to certain types of changes (ie. mutation in a gene). Additionally, there is the possibility that a gene alteration of unknown significance may be identified.

3. The accuracy of genetic testing is limited by the test methods used, the clinical diagnosis, the nature of the specific condition for which testing is requested and the reported family relationships. An inaccurate clinical diagnosis in the patient or family members can lead to an incorrect interpretation of the test result.
   - Genetic tests are relatively new and are continuously being expanded and improved. The tests are not considered research, but are considered to be the best and newest laboratory service available at the time of testing. This testing is complex and utilizes specialized materials so that there is always a very small possibility that the test will not work properly or that an error will occur. A low error rate, estimated to be approximately 1 in 1000 sample is thought to exist in even the best labs.
   - Genetic testing in family members may disclose true biological relationships are inconsistent with what has been shared with the lab. For example, non-paternity may be detected, which means that the stated father of an individual is not the true biological father.
   - DNA testing performed is specific for the condition and in no way guarantees my health or the health of my living or unborn children. The accuracy of test interpretation is dependent on the clinical diagnosis provided to the lab, and Molecular Vision Laboratory cannot be responsible for inaccurate clinical diagnoses made elsewhere.

4. Due to the complexity of the DNA-based testing, and the potential implications of the test results, results will be reported directly to the physician or genetic counselor who ordered the testing so that appropriate genetic counseling services can be provided. **Results are confidential and will only be released to other medical professional or parties with my written consent in accordance with Oregon Genetic Privacy Statutes.**

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5. The Molecular Vision Laboratory is not a DNA banking facility and cannot guarantee the future availability of patient DNA. Requests for additional studies may be made by the referring provider and additional fees may apply.

6. Once testing is complete, patient identifiers may be removed and remaining DNA samples may be used for laboratory purposes, including anonymous research. These samples will not be available for future clinical studies. Results from such testing cannot be attributed to specific patients and the results will not be reportable.

I can request that remaining DNA <u>not</u> be used for research purposes by initialing here: _____

7. Although there are federal, and in some instances additional state laws, protecting individuals from discrimination based genetic disease status, there is potential for insurance, employment and social discrimination should your genetic information become known to others.

The risks, benefits and limitations of DNA testing have been explained to me. I have read and will receive a copy of this consent form.

_____ / / : ☐ am ☐ pm
Patient Signature Date Time

_____ / / : ☐ am ☐ pm
Parent/ Guardian Signature Date Time

Physician/Genetic Counselor/Ordering Provider Statement:
I have provided a detailed explanation of the risks, benefits and limitations of genetic testing to the patient/parent/guardian. I have reviewed this consent form in its entirety and I have answered patient/guardian questions.

_____ / / : ☐ am ☐ pm
Clinician Name (printed) Clinician Signature Date Time