Molecular Vision Laboratory Requisition Form
molecularvisionlab.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*: ______________________

Biological Gender*: ______________________

Parent Name (if patient is a minor): ______________

Race/Ethnicity: ______________________

Email*: ______________________

Ordering Provider

Name*: ______________________

Institution (if applicable): ______________________

Address: ______________________

City: ______________ **State/Pr:** ______ **Zip:** ______

Phone: ______________________

Email (required for International clients):

____

Report Delivery Method: ______________________

Genetic Counselor

Name: ______________________

Phone: ______________________

Email: ______________________

Report Delivery Method: ______________________

Referring Hospital or Laboratory (if applicable)

Name: ______________________

Address: ______________________

City: __________ **State/Pr:** ________ **Zip:** ______

Phone: ______________________

Email: ______________________

Report Delivery Method: ______________________

Specimen Information

Date/Time Collected: ______________________

Sample Type*: ______________________

Additional cost for shipping and saliva kits will be charged. $20 for shipping within the U.S. (two-ways). $10 for each saliva kit.

☐ **Ship to patient address (LEFT)**

☐ **Ship to other:** **Address:** ______________________

City: __________ **State/Pr:** ______ **Zip:** ________

Test Requested

Disease Name: ______________________

Testing for known mutation: ______________________

Mutation: ______________________

Name/ID of Relative (proband): ______________________

Relationship to proband: ______________________

If expedited testing is requested, please indicate reason:

☐ Pregnancy: Gestational Age (weeks): ________

☐ Other: Reason ______________________

Ordered Test

Panel: ______________________

Other Panel (if none from above)*: ______________________

Price*: ______________________

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

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

*Required field

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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: ______________________________

Clinical Diagnosis:______________________________

Reason for Testing

Please indicate Payment Method:______________________________

Institutional and Sponsor 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

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Self-Pay 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):____________________

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).

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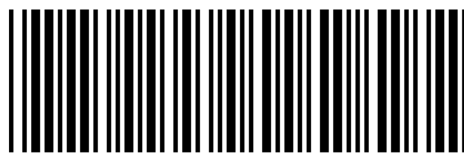

MED. REC. NO. ______________________
NAME: ______________________
BIRTHDATE: ______________________

MVL

Patient Identification

ACCOUNT NO. ______________________

I, ______________________ **voluntarily** request the Molecular Vision Laboratory, Inc to perform DNA-based testing for myself ______________________ 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 oft he 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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ACCOUNT NO. ______
MED. REC. NO. ______
NAME: ______
BIRTHDATE: ______

Patient Identification

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 not 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 (MM/DD/YYYY) Time

______ / / : ☐ AM ☐ PM
Parent/ Guardian Signature Date (MM/DD/YYYY) 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.

Clinician Name (printed): ______

______ / / : ☐ AM ☐ PM
Clinician Signature Date (MM/DD/YYYY) Time

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