

Genetics Test Requisition



MOLECULAR VISION

1920 NE Stucki Ave # 150 Hillsboro OR 97006

PHONE: 503-227-3179

FAX: 503-227-3157

EMAIL: inquiry@mvisionlab.com

PRIMARY PATIENT			
LAST NAME		FIRST NAME	
DATE OF BIRTH (MM/DD/YYYY)		GENETIC SEX Male Female Unknown	
ADDRESS		ETHNICITY	
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE		EMAIL	
Saliva Collection Kits available by USPS priority shipping for \$30 (fee waived for orders of \$300 or more)			
Send kit to address above		Send kit to alternate address	

ORDERING PROVIDER	
INSTITUTION/PRACTICE NAME	INSTITUTION PHONE/FAX/EMAIL
PROVIDER LAST NAME	PROVIDER FIRST NAME
NPI (USA) / MINC (CANADA)	EMAIL
PROVIDER PHONE	DELIVER REPORT TO
COLLECTION DATE (MM/DD/YYYY)	SAMPLE TYPE Blood Saliva Other:
MRN / Patient ID	GENETIC COUNSELOR

MEDICAL HISTORY
Fill out medical history or attach documentation

BILLING			
Self Pay MVL staff will email you to setup payment	Institutional	ICD-10 DIAGNOSIS CODE	REFERRAL/PRIOR AUTH
Institutional Only			
HOSPITAL / LAB NAME	CONTACT NAME	EMAIL	
PHONE NUMBER	PO# / DEPT CODE (IF USED)	ADDRESS (IF DIFFERENT)	

TEST REQUESTED	
	OTHER
PRICE	

<p>MVL is committed to support you with your share of costs. If required, you will be contacted by our team to setup a payment plan for your portion of the costs using the following forms of payment: Check, Visa, Master Card.</p>		<p>I attest that the patient has received and read the MVL Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any MVL Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.</p> <p>STATEMENT OF MEDICAL NECESSITY By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.</p>	
PATIENT SIGNATURE X	DATE (MM/DD/YYYY)	PROVIDER SIGNATURE X	DATE (MM/DD/YYYY)

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SECOND PAGE OPTIONAL

PATIENT BILLING INFORMATION		MVL staff will email patient for billing if this section is left blank	
NAME ON CARD	CARD NUMBER	EXPIRATION	CVV
PAYMENT AMOUNT			