MEDEX LABORATORIES

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PLEASE SUBMIT THE FOLLOWING WITH REQUISITION FORM

1. Clinical Notes 2. Pedigree 3. Insurance Card

CARDIOVASCULAR TEST REQUISITION FORM - PAGE 1 OF 2

COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS

PATIENT INFORMATION

First Name	Last Name
Date of Birth (MM/DD/YYYY)	Phone
Email	
Address	
City / State / Zip	

Gender F ☐ M ☐

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish(Ashkenazi) ☐ Portuguese ☐ Other

FAMILY HISTORY*

☐ None (Maternal) ☐ None (Paternal) ☐ Maternal hx unknown ☐ Paternal hx unknown

*Completing this section is not mandatory for ordering, but recommended and helps with claims filing. Pedigree and other clinical family history notes should be supplied as well when sending in your order.

Relation to Patient	Mat	Pat	H/o cardio disease	Dx age
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

SPECIMEN INFORMATION*

☐ Buccal Swab:

Collection Date:	Collection Time:	Medical Record#:

ORDERING PHYSICIAN/SENDING FACILITY (Each Listed person will receive a copy of the report)

Facility Name (Facility Code):	Address:	City:
State/Country :	Zip:	Phone:

Health Provider Name (Last, First):	NPI#:	Phone:	Fax/Email:

Additional Results Recipients

Genetic Counselor or Other Medical Provider Name (Last, First)(Code):	Phone/Fax/Email:

Medical Professional Signature: **Date :**

☐ INSURANCE BILLING (Include copy of both sides of insurance card)

Patient Relation to Policy Holder? ☐Self ☐Spouse ☐Child

Name of Policy Holder (If not self) DOB:

Insurance Company:	Policy#	HMO#

Out Of Pocket:

We will start testing immediately unless you check the box below. We will attempt to contact you if estimated out-of- Pocket costs are > USD $100.

☐ Do not start testing until I approve payment terms regarding estimated out-of-pocket costs

Patient agrees to contact regarding out-of-pocket amount by:

☐ Email ☐ Phone(includes tests) - confirm mobile # .....

Special Billing Notes:

☐ INSTITUTIONAL BILLING

Facility Name: ☐ Send Invoice to facility address above

Address:

Contact Name:

Phone Number:	E-mail/Fax:
☐ Patient Payment	☐Check (Payable To) ☐Credit Card (Call 949-900-5795)

INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)

☐ Diagnostic ☐ Family history ☐Positive or normal control ☐Other.....ICD-10 code(s):.....

Will Patient management be changed depending on the test results? ☐Yes☐ No ☐ STAT TEST : Date results needed (if Known):.....

CARDIOVASCULAR TEST REQUISITION FORM - PAGE 2 OF 2

CLINICAL HISTORY (PLEASE SUPPLY CLINIC NOTES AND PEDIGREE)

☐ No personal history of cardiovascular disease

Sudden Cardiac arrest ☐ Y ☐ N (if yes): # Episodes:.....Age first incident:.....

Syncope ☐ Y ☐ N (if yes): Episodes:.....Age first incident:.....

History of Cardiovascular ☐ Y ☐ N Age at dx:.....

Type(s) of Cardiovascular:.....

History of Arrhythmia ☐ Y ☐ N Age at dx:.....

Types (s) of Arrhythmia:.....

☐ Clinical diagnosis of Marfan Syndrome or other connective tissue disorder

☐ Aortic Aneurysm/Dilation Age at dz:..... z-score:.....

☐ Other Aneurysm Location: .....Age at dz:.....

☐ Aortic/Vascular Dissection Location:.....Age at dz:.....

☐ History of Familial hypercholesterolemia

☐ Other history:.....

CLINICAL TESTING AND PROCEDURES

LDL-C:.....Total Cholesterol:.....Age at Testing:.....

Procedures (e.g.: EKG, EHCO, etc.) Age:.....Result (e.g.: LVIDd. PWd, Qtc, etc):.....Type:.....

Cardiovascular Device implement (eh: Pacemaker, ICD, LVAD, etc.): Age at implementation:.....

PREVIOUS GENETIC TESTING

(PLEASE INCLUDE COPIES OF ANY PREVIOUS TEST RESULTS)

Test

Laboratory

Results

Comprehensive Cardiovascular Panel

AGL, ACTA1, ACTN2, RYR2, TNNT2, LMNA, RBM20, VCL, COX15, BAG3, CSRP3, MYBPC3, CRYAB, CBL, APOA1, PKP2, MYL2, CACNA1C, ABCC9, MYH7, TPM1, ACTC1, HCN4, JUP, ACADVL, ELAC2, GAA, TCAP, DSG2, TTR, EPG5, DSC2, TNNI3, FKRP, DES, TTN, RAF1, SCN5A, TMEM43, MYL3, ACAD9, TNNC1, CAV3, SLC25A4, SGCD, SLC22A5, NDUFAF2, PLN, DSP, EYA4, AGK, PRKAG2, FLNC, FKTN, FXN, DOLK, GLA, LAMP2, DMD, FHL1, EMD, TAZ

ICD-10 DIAGNOSIS CODES WITH DESCRIPTION

E78.4 - Other Hyperlipidemia
E78.5 - Hyperlipidemia, unspecified
E87.1 - Hypo - osmolality and / or hypernatremia
G89.29 - Other Chronic Pain
I10 - Essential (Primary) Hypertension
I25.10 - Atherosclerotic heart disease of native coronary artery without angina pectoris
I25.5 - Ischemic Cardiovascular
I25.6 - Silent Myocardial Ischemia
I25.89 - Other forms of chronic ischemic heart disease
I25.9 - Chronic ischemic heart disease, unspecified
I34.1 - Nonrheumatic mitral (valve) insufficiency
I34.1 - Nonrheumatic mitral (valve) prolapse
I34.2 - Nonrheumatic mitral (valve) stenosis
I35.8 - Other nonreheumatic mitral valve disorders
I34.9 - Nonrheumatic mitral valve disorder, unspecified
I35.0 - Nonrheumatic aortic (Valve) stenosis
I35.1 - Nonrheumatic aortic (Valve) Insufficiency
I35.2 - Nonrheumatic aortic (valve) stenosis with insufficiency
I35.8 - Other Nonrheumatic aortic (valve) disorders
I35.9 - Nonrheumatic aortic valve disorder, unspecified
I42.0 - dilated Cardiovascular
I42.5 - Other restrictive Cardiovascular
I42.9 - Supraventricular tachycardia
I49.2 - Junctional premature depolarization
I48.0 - Paroxysmal atrial fibrillation
I48.2 - Chronic atrial fibrillation
I49.91 - Unspecified atrial fibrillation
I49.8 - Other specified cardiac arrhythmias
R00.1 - Bradycardia, unspecified
I50.9 - Heart Failure, unspecified
I50.21 - Acute systolic (congestive) heart failure
I50.22 - Chronic systolic(congestive) heart failure
I50.32 - Chronic diastolic (congestive) heart failure
I50.33 - Acute on chronic diastolic (congestive) heart failure
I51.9 - Heart disease, unspecified
I52 - Other heart diseases classified elsewhere
R55 - Syncope and Collapse
R60.0 - Localized edema
I0 E78.01 - Familial hypercholesterolemia
R60.1 - Generalized edema
R60.9 - Edema, unspecified
R00.2 - Palpitations
R06.02 - Shortness of breath
R06.00 - Dyspnea, unspecified
R06.09 - Other forms of dyspnea
PR06.3 - Periodic breathing
R06.83 - Snoring
R06.89 - Other abnormalities of breathing
R07.9 - Chest pain, unspecified
R07.2 - Precordial pain
R07.82 - Intercostal pain
R07.89 - Other chest pain
R94.31 - Nonspecific abnormal electrocardiogram (ECG)(EKG)
Z79.01 - Long term (current) use of anticoagulants
Z01.810 - Encounter for preprocedural cardiovascular examination
Z01.812 - Encounter for preprocedural laboratory examination
Z01.818 - Encounter for other preprocedural examination

PATIENT SIGNATURE

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to **Medex Laboratories Inc**. its assigned affiliates and authorized representatives for laboratory services furnished to me by **Medex Laboratories Inc.** I irrevocably designate, authorize and appoint **Medex Laboratories Inc.** or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, Summary Plan Description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to **Medex Laboratories Inc.** immediately upon receipt. I hereby authorize **Medex Laboratories Inc.** its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to **Medex Laboratories Inc.,** in compliance with federal and state laws. **Medex Laboratories Inc.,** its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of **Medex Laboratories Inc.** and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature of Patient or Patient Representative / Relationship to Patient Date:

ORDERING PHYSICIAN SIGNATURE

Physician must only order tests that are medically necessary for the diagnosis or treatment of a patient

I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder and that the results will be used in medical management and care decisions for the patient. Furthermore, all information on this Requisition Form is true to the best of my knowledge. I agree to provide the Care Plan notes and Letter of Intent for this order if the insurance requests the lab to gather the medical necessity for any reason

Ordering Physician Signature Date: