

2010 Test Request Form



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|--|---|
| <input type="checkbox"/> Apolipoprotein E Genotyping | <input type="checkbox"/> PAI-1 Gene Polymorphism (4G vs 5G) |
| <input type="checkbox"/> Dihydropyrimidine Dehydrogenase (DPD)
(GT to AT causing skipping of exon 14) | <input type="checkbox"/> Prothrombin 3' UT (G20210A) |
| <input type="checkbox"/> eNOS T-786C Mutation
(Endothelial Nitric Oxide Synthase) | <input type="checkbox"/> Factor V (Leiden) Mutation |
| <input type="checkbox"/> Glycoprotein IIIa (A1 vs A2 polymorphism) | <input type="checkbox"/> Stromelysin-1 5A vs 6A |
| <input type="checkbox"/> MTHFR C677T Mutation | <input type="checkbox"/> MTHFR A1298C Mutation |
| <input type="checkbox"/> †*Warfarin Metabolism Panel
(VKORC1, CYP2C9*2 & CYP2C9*3)
Height required for warfarin starting dose. Height: _____
†Not approved in the State of New York
*See our web site for the dosing algorithm | <input type="checkbox"/> †UGT1A1 (Camptosar Metabolism) |

Patient Information **REQUIRED**

Name: _____
Address: _____

SSN: _____

DOB: _____

SEX: Male _____ Female _____

ICD-9 code(s): _____

Draw Date: _____ MR#: _____

Diagnosing: _____

**Bill To: Hospital/Facility/Clinic/Patient/
Insurance** (please circle one) **REQUIRED**

Name: _____

Address: _____

(For insurance billing)

Policy Holder: _____

Policy #: _____

Group #: _____

If you would like MDL to bill the medical insurance company, please provide a copy of the insurance card, front and back. For additional information please visit our website:

www.mdl-labs.com.

Informed consent: ___ YES ___ NO (Required for all N.Y. State residents for genetic testing.)

Molecular Diagnostics Laboratories

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CLIA # 18D1100471 NY Permit PFI:7902

Physician Information **REQUIRED**

Name: _____
Address: _____

Phone: _____

Fax: _____

Physician's UPIN # _____

NPI # _____

Send Results To: **REQUIRED**

Name: _____

Address: _____

Phone: _____

Fax: _____

Phone: (513) 437-3000 Ext: 306

Fax: (859) 581-4086