

# 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)<br>(GT to AT causing skipping of exon 14)   | <input type="checkbox"/> Prothrombin 3' UT (G20210A)         |
| <input type="checkbox"/> eNOS T-786C Mutation<br>(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<br>(VKORC1, CYP2C9*2 & CYP2C9*3)<br>Height required for warfarin starting dose. Height: _____<br>†Not approved in the State of New York<br>*See our web site for the dosing algorithm |  |

**Patient Information: (REQUIRED)**

Name : \_\_\_\_\_  
Address : \_\_\_\_\_  
SSN : \_\_\_\_\_  
DOB : \_\_\_\_\_  
SEX : Male \_\_\_\_\_ Female \_\_\_\_\_  
ICD-9 code(s): \_\_\_\_\_  
Draw Date: \_\_\_\_\_ MR#: \_\_\_\_\_  
Diagnosing: \_\_\_\_\_

**Physician Information: (REQUIRED)**

Name : \_\_\_\_\_  
Address : \_\_\_\_\_  
Phone : \_\_\_\_\_  
Fax : \_\_\_\_\_  
Physician's UPIN #: \_\_\_\_\_  
NPI # : \_\_\_\_\_

**Bill To: (REQUIRED)**

**Hospital/Facility/Clinic/Patient** (please circle one)

Name : \_\_\_\_\_  
Address : \_\_\_\_\_

**Send Results To: (REQUIRED)**

(results cannot be sent directly to the patient)

Name : \_\_\_\_\_  
Address : \_\_\_\_\_  
Phone : \_\_\_\_\_  
Fax : \_\_\_\_\_

**Note:** We currently cannot bill the insurance companies.

For additional information please visit our website: [www.mdl-labs.com](http://www.mdl-labs.com).

**Informed Consent :** \_\_\_ YES \_\_\_ NO (Required for all N.Y. State residents for genetic testing.)

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