



Test Request Form

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

Patient Information

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

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

Name: _____
Address: _____
(For insurance billing)
Policy Holder: _____
Policy #: _____
Group #: _____

Physician Information

Name: _____
Address: _____
Phone: _____
Fax: _____
Physician's UPIN # _____
NPI # _____

Send Results To:

Name: _____
Address: _____
Phone: _____
Fax: _____

If you would like MDL to bill the medical insurance company, please provide a copy of the insurance card, front and back. For more information about CPT codes, TAT, individual tests, examples of reports please visit our web site: www.mdl-labs.com

Informed consent: ___ YES ___NO (Required for all N.Y. State residents for genetic testing.)

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