SHODAIR CHILDREN'S HOSPITAL GENETICS LABORATORY
2755 Colonial Dr, Helena. MT, 59601 (406) 444-7532 (800) 447-6614
Fax (406) 444-1022, email: mtgene@shodair.org

SHODAIR LAB #:

DRUG METABOLIZING ENZYMES (CYTOCHROME P450) TEST REQUEST FORM

(Please send this completed form with the specimen)

PATIENT LAST NAME: ______________________________ **FIRST NAME** : ________________________________ **DOB**:__________

SEX: M / F **REF. LAB #:** ______________________ **DATE COLLECTED**:________________ **DATE RECEIVED:** ________________

ETHNIC BACKGROUND: (Circle all that apply) European Caucasian, Hispanic, Native American, African American, Asian, Other

REFERRING PHYSICIAN/ HEALTH PROFESSIONAL:
Name: ____
Address: ____
City, State, Zip: ___________________________________
Telephone:(____)___________FAX:(____)___________

REFERRING INSTITUTION / CLINIC / LABORATORY:
Name: ____

ADDITIONAL REPORTS TO:
Name: ____

PHYSICIAN SIGNATURE: **Date:**
(required for Medicare / Medicaid billing)

BILLING INFORMATION:
- ❑ **REFERRING INSTITUTION**

New clients please call laboratory with financial contact information.

- ❑ **INSURANCE**

Name of policy holder:___________________________
Policy holder DOB:_____________________________
SS # (Guarantor): ______________________________
Address:_____________________________________
Phone #:___________________________________
Relationship to patient:_________________________
Insurance Co. / Policy #:________________________
Insurance Co Contact / Phone #:_________________

- ❑ **Medicaid #:**_______________

State (MT, WY, CO, UT): ___________
SS#:___________________________

- ❑ **SELF PAY**
- ❑ **Inpatient**

TEST REQUESTED: (Please check one or more; test descriptions with CPT codes and prices faxed on request)

- ❑ **Drug Metabolizing Enzymes Panel (CYP2D6, CYP2C9, CYP2C19)**
- ❑ **CYP2D6**
- ❑ **CYP2C9**
- ❑ **CYP2C19**

SPECIMEN TYPE: PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT

- ❑ **Blood** – EDTA (purple top), 5-10 ml, room temp
- ❑ **STAT (Additional charges apply)**

- ❑ **If test results are ABNORMAL, contact ordering physician about Pharmacogenetic Consultation services**

DIAGNOSIS:

Reason for testing: ( ) **limited response/no therapeutic benefit** ( ) **ADR/drug sensitivity/toxicity** ( ) **Other:**

STATEMENT OF CONSENT AND RELEASE (Sample will not be processed until consent is obtained)

I hereby certify that the information provided is true and accurate. I consent to the collection of specimens for the purpose of DNA testing. I understand and agree that Shodair Medical Genetics Laboratory reserves the right to request re-collection of samples for retesting and to store samples for future additional tests, if necessary.

I understand that while DNA testing is highly accurate and widely accepted, as in all testing there is a possibility of delay or error. I understand that samples and the DNA they contain become the exclusive property of Shodair Hospital. I also understand that prescription drug dosages and schedules should never be altered without consulting a physician.

Shodair Hospital will not release personal, identifiable information of any kind to a third party without my express written instructions. I also understand and agree that Shodair Hospital reserves the right to provide de-identified information of a statistical nature to accrediting agencies and reserves the right to use any such anonymous information for research purposes.

____ **Date:** ____________________
Patient signature (If minor/or unable to consent, signature of legal guardian or conservator)

____ **Date**: ____________________
Phone Consent obtained from Patient/Legal Guardian/Conservator

____ **Date:** ____________________
Physician or RN witness to In-Person and/or Phone Consent

Med Red #:	**Admit #:**	**Shire #:**