

SHODAIR LAB #:

## DRUG METABOLIZING ENZYMES (CYTOCHROME P450) TEST REQUEST FORM

*(Please send this completed form with the specimen)*

PATIENT LAST NAME: \_\_\_\_\_ FIRST NAME : \_\_\_\_\_ SOC. SEC. #: \_\_\_\_\_  
 DOB: \_\_\_/\_\_\_/\_\_\_ SEX: M / F / Unk REF. LAB #: \_\_\_\_\_ DATE COLLECTED: \_\_\_/\_\_\_/\_\_\_ DATE RECEIVED: \_\_\_/\_\_\_/\_\_\_  
 Resp. Party (Relation to Pt): \_\_\_\_\_ Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
**ETHNIC BACKGROUND:** (Circle all that apply) European Caucasian, Hispanic, Native American, African American, Asian, Other

<p><b>REFERRING PHYSICIAN/ HEALTH PROFESSIONAL:</b>                  Name: _____                  Address: _____                  City, State, Zip: _____                  Telephone: (____) _____ FAX: (____) _____</p> <p><b>REFERRING INSTITUTION / CLINIC / LABORATORY:</b>                  Name: _____                  Address: _____                  City, State, Zip: _____                  Telephone: (____) _____ FAX: (____) _____</p> <p><b>ADDITIONAL REPORTS TO:</b>                  Name: _____                  Address: _____                  City, State, Zip: _____                  Telephone: (____) _____ FAX: (____) _____</p>	<p><b>BILLING INFORMATION: (Check)</b></p> <p><input type="checkbox"/> <b>REFERRING INSTITUTION / CLINIC / OFFICE</b>                  Institution Name: _____ Inpatient: Yes No                  Billing Address: _____                  Financial Contact: _____ Telephone: (____) _____</p> <p><input type="checkbox"/> <b>INSURANCE</b>                  Commercial: Provide front / back copy of card                  Managed Care (HMO): Copy of card with authorization                  Medicaid (MT, WY, CO, UT, CA, ID): Copy of card                  Name of Policy Holder: _____                  Insurance Co / Policy #: _____                  Insurance Co Contact / Phone #: _____                  SS # (Guarantor): _____                  Medicaid # / State: _____</p> <p><input type="checkbox"/> <b>SELF PAY</b> (Please call the laboratory to arrange)</p>
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**TEST REQUESTED: (Please check one or more; test descriptions with CPT codes and prices faxed on request)**

<p><input type="checkbox"/> <b>Drug Metabolizing Enzymes Panel (CYP2D6, CYP2C9, CYP2C19)</b></p> <p><input type="checkbox"/> CYP2D6  <input type="checkbox"/> CYP2C9  <input type="checkbox"/> CYP2C19</p> <p><input type="checkbox"/> <b>If test results are ABNORMAL, contact ordering physician about Pharmacogenetic Consultation services</b></p>	<p><b>SPECIMEN TYPE:</b>  <b>Blood - One (1) EDTA (purple top tube)</b>                  5 to 10 ml, min., 1 ml for infant, room temperature</p> <p style="text-align: center;"><b>PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT</b>                  1-800-447-6614, ext. 7532</p> <p><input type="checkbox"/> <b>STAT</b> (Additional charges apply)</p>
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**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.

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 Phone Consent	Date: