

PHARMACOGENETIC CONSULT REQUEST FORM

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

<p>REFERRING PHYSICIAN/ HEALTH PROFESSIONAL: Name: _____ Address: _____ City, State, Zip: _____ Telephone:(_____) _____ FAX:(_____) _____</p>	<p>REFERRING INSTITUTION / CLINIC / LABORATORY: Name: _____</p> <p>ADDITIONAL REPORTS TO: Name: _____</p>
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SERVICE REQUESTED: Pharmacogenetic consult based upon primary diagnosis, Cytochrome P450 test results, medication records and history (as provided and applicable).

PHYSICIAN SIGNATURE: _____ **Date:** _____

<p>BILLING INFORMATION: <input type="checkbox"/> REFERRING INSTITUTION</p> <p>New clients please call laboratory with financial contact information.</p>	<p><input type="checkbox"/> INSURANCE Name of policy holder: _____ Policy holder DOB: _____ SS # (Guarantor): _____ Address: _____ Phone #: _____ Relationship to patient: _____ Insurance Co. / Policy #: _____ Insurance Co Contact / Phone #: _____</p>	<p><input type="checkbox"/> Medicaid #: _____ State (MT, WY, CO, UT): _____ SS#: _____</p> <p><input type="checkbox"/> SELF PAY</p> <p><input type="checkbox"/> Inpatient</p>
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<p><u>CLINICAL INFORMATION:</u></p> <p>DIAGNOSIS: _____</p> <p>_____</p> <p>Liver Disease YES / NO Kidney Disease YES / NO Diabetes YES / NO</p> <p>OTHER (attach additional sheet if needed): _____</p> <p>REASON FOR TESTING:</p> <p><input type="checkbox"/> Adverse event/drug sensitivity/ toxicity <input type="checkbox"/> Limited response/no therapeutic benefit <input type="checkbox"/> Family history of adverse drug reaction <input type="checkbox"/> Pre-therapeutic testing <input type="checkbox"/> Other _____</p> <p>PRN/OTC MEDICATIONS:</p> <p><input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> Loratadine (Alavert, Claritin) <input type="checkbox"/> OTHER _____</p> <p>HERBALS/SUPPLEMENTS:</p> <p><input type="checkbox"/> St. John's Wort <input type="checkbox"/> Ginko OTHER _____</p>	<p>PRESCRIPTIONS:</p> <p><input type="checkbox"/> Amitriptyline <input type="checkbox"/> Anafranil (clomipramine hydrochloride) <input type="checkbox"/> Aripiprazole (Abilify) <input type="checkbox"/> Atomoxetine HCL (Strattera) <input type="checkbox"/> Benztropine <input type="checkbox"/> Bupropion SR or XL (Wellbutrin) <input type="checkbox"/> Buspirone <input type="checkbox"/> Carbamazepine <input type="checkbox"/> Chlorpromazine <input type="checkbox"/> Citalopram <input type="checkbox"/> Clonidine (Catapres) <input type="checkbox"/> Clonazepam <input type="checkbox"/> Clozapine <input type="checkbox"/> Cyclobenzaprine <input type="checkbox"/> Dextroamphetamine <input type="checkbox"/> Dextroamphetamine/ Amphet. (Adderall) <input type="checkbox"/> Diazepam (Valium) <input type="checkbox"/> Divalproex Sodium (Valproic acid) <input type="checkbox"/> Duloxetine (Cymbalta) <input type="checkbox"/> Escitalopram (Lexapro) <input type="checkbox"/> Fluconazole (Diflucan) <input type="checkbox"/> Fluoxetine (Prozac) <input type="checkbox"/> Fluvoxamine <input type="checkbox"/> Guaifenesin/Dextromethorphan <input type="checkbox"/> Haloperidol (Haldol) <input type="checkbox"/> Hydroxyzine (Vistaril) <input type="checkbox"/> Imipramine (Tofranil) <input type="checkbox"/> Lithium (Eskalith, Lithobid) <input type="checkbox"/> Lorazepam (Ativan) <input type="checkbox"/> Loxapine (Loxitane) <input type="checkbox"/> Methylphenidate (Concerta, Metadate, Ritalin)</p>	<p><input type="checkbox"/> Metronidazole <input type="checkbox"/> Mirtazapine (Remeron) <input type="checkbox"/> Montelukast sodium (Singulair) <input type="checkbox"/> Nefazodone <input type="checkbox"/> Olanzapine (Zyprexa) <input type="checkbox"/> Omeprazole (Prilosec) <input type="checkbox"/> Oral contraceptives: _____ <input type="checkbox"/> Oxcarbazepine (Trileptal) <input type="checkbox"/> Oxybutynin (Ditropan) <input type="checkbox"/> Paroxetine (Paxil) <input type="checkbox"/> Perphenazine <input type="checkbox"/> Phenytoin (Dilantin) <input type="checkbox"/> Promethazine <input type="checkbox"/> Promethazine/Codeine <input type="checkbox"/> Propoxyphene/APAP (Tylenol w/ codeine) <input type="checkbox"/> Propranolol (Inderal) <input type="checkbox"/> Pseudoephed./Chlorpheniramine <input type="checkbox"/> Quetiapine (Seroquel) <input type="checkbox"/> Ranitidine (Zantac) <input type="checkbox"/> Risperidone (Risperdal) <input type="checkbox"/> Sertraline (Zoloft) <input type="checkbox"/> Somatropin (Genotropin, Humatrope) <input type="checkbox"/> Sulfamethoxazole/Trimethoprim <input type="checkbox"/> Topiramate (Topamax) <input type="checkbox"/> Tramadol (Ultram) <input type="checkbox"/> Trazodon <input type="checkbox"/> Venlafaxine (Effexor) <input type="checkbox"/> Ziprasidone (Geodon) <input type="checkbox"/> OTHER: _____</p> <p>_____</p> <p>_____</p> <p><i>Attach additional sheet if needed</i></p>
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Med Red #:	Admit #:	Shire #:
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