

SHODAIR LAB #:

PHARMACOGENETIC CONSULT REQUEST FORM

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	
REFERRING PHYSICIAN/ HEALTH PROFESSIONAL: Name: _____ Address: _____ City, State, Zip: _____ Telephone:(____) _____ FAX:(____) _____ SERVICE REQUESTED: Pharmacogenetic consult based upon primary diagnosis, Cytochrome P450 test results, medication records and history (as provided and applicable). _____ Provider signature Date: _____	BILLING INFORMATION: (Check) <input type="checkbox"/> REFERRING INSTITUTION / CLINIC / OFFICE Institution Name: _____ Inpatient: Yes No Billing Address: _____ Financial Contact: _____ Telephone: (____) _____ <input type="checkbox"/> INSURANCE 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: _____ <input type="checkbox"/> SELF PAY (Please call the department to arrange)

CLINICAL INFORMATION:

DIAGNOSIS: _____

Liver Disease YES / NO

Kidney Disease YES / NO

Diabetes YES / NO

OTHER (attach additional sheet if needed): _____

REASON FOR TESTING:

- Adverse event/drug sensitivity/ toxicity
- Limited response/no therapeutic benefit
- Family history of adverse drug reaction
- Pre-therapeutic testing
- Other _____

PRN/OTC MEDICATIONS:

- Diphenhydramine (Benadryl)
- Loratadine (Alavert, Claritin)
- OTHER _____

HERBALS/SUPPLEMENTS:

- St. John's Wort
- Ginko
- OTHER _____

PRESCRIPTIONS:

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Amitriptyline <input type="checkbox"/> Anafranil (clomipramine hydrochloride) <input type="checkbox"/> Aripiprazole (Abilify) <input type="checkbox"/> Atomoxetine HCL (Strattera) <input type="checkbox"/> Bzotropine <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) <input type="checkbox"/> Metronidazole | <ul style="list-style-type: none"> <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 <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: _____ |
|--|--|

Attach additional sheet if needed

