

SHODAIR LAB #:

WARFARIN SENSITIVITY 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: _____
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PHYSICIAN SIGNATURE: _____ **Date:** _____
 (Required for Medicare / Medicaid billing)

BILLING INFORMATION: <input type="checkbox"/> REFERRING INSTITUTION New clients please call laboratory with financial contact information.	<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 #: _____	<input type="checkbox"/> Medicaid #: _____ State (MT, WY, CO, UT): _____ SS#: _____ <input type="checkbox"/> SELF PAY <input type="checkbox"/> Inpatient
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DIAGNOSIS: _____

TEST REQUESTED: <input type="checkbox"/> Warfarin Sensitivity Test (CYP2C9 and VKORC1) <input type="checkbox"/> Warfarin Sensitivity Test plus Drug Metabolizing Enzyme Panel (CYP2D6, CYP2C19, CYP2C9, and VKORC1) <input type="checkbox"/> If combined panel test results are ABNORMAL , please contact ordering physician about Pharmacogenetic Consultation SPECIMEN TYPE: Peripheral Blood One (1) EDTA (purple top) tube 5 to 10 ml, room temperature PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT	INDICATION: <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Cardioembolic stroke <input type="checkbox"/> Deep venous thrombosis <input type="checkbox"/> Hip fracture <input type="checkbox"/> Heart failure/cardiomyopathy <input type="checkbox"/> Knee replacement <input type="checkbox"/> Heart valve replacement <input type="checkbox"/> Hip replacement <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Other _____	CLINICAL INFORMATION: Age: _____ Weight: _____ lbs. or kgs. Height: _____ feet and inches or cms Baseline INR: _____ Target INR: _____ REASON FOR TEST: <input type="checkbox"/> Pre-therapeutic testing <input type="checkbox"/> Adverse drug reaction / drug sensitivity or toxicity <input type="checkbox"/> Limited response / no therapeutic benefit <input type="checkbox"/> Family history of adverse drug reaction <input type="checkbox"/> Other _____
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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 Children's Hospital's 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 Children's Hospital. I also understand that prescription drug dosages and schedules should never be altered without consulting a physician.

Shodair Children's 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 Children's 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:** _____

Med Rec #	Admit #	Shire #
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