

SHODAIR LAB #:

WARFARIN SENSITIVITY 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

REFERRING PHYSICIAN/ HEALTH PROFESSIONAL:

Name: _____
Address: _____
City, State, Zip: _____
Telephone: (____) _____ FAX: (____) _____

REFERRING INSTITUTION / CLINIC / LABORATORY:

Name: _____
Address: _____
City, State, Zip: _____
Telephone: (____) _____ FAX: (____) _____

ADDITIONAL REPORTS TO:

Name: _____
Address: _____
City, State, Zip: _____
Telephone: (____) _____ FAX: (____) _____

BILLING INFORMATION: (Check)

REFERRING INSTITUTION / CLINIC / OFFICE

Institution Name: _____ Inpatient: Yes No

Billing Address: _____

Financial Contact: _____ Telephone: (____) _____

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: _____

SELF PAY (Please call the laboratory to arrange)

DIAGNOSIS: _____

TEST REQUESTED:

Warfarin Sensitivity Test
(CYP2C9 and VKORC1)

Warfarin Sensitivity Test plus Drug
Metabolizing Enzyme Panel
(CYP2D6, CYP2C19, CYP2C9, and VKORC1)

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:

- Atrial fibrillation
- Cardioembolic stroke
- Deep venous thrombosis
- Hip fracture
- Heart failure/cardiomyopathy
- Knee replacement
- Heart valve replacement
- Hip replacement
- Pulmonary embolism
- Pulmonary hypertension
- Other _____

CLINICAL INFORMATION:

Age: _____

Weight: _____ lbs. or kgs.

Height: _____
feet and inches or cms

Baseline INR: _____

Target INR: _____

REASON FOR TEST:

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