DNA TEST REQUEST FORM

Please indicate the purchase of a single test or a panel.

Instructions
Fill in all fields on this form – *incomplete data will delay testing.*
Print three copies – *one for the laboratory, the patient and the patient's file.*
Results will be faxed directly to the physician.

Pricing	
☐**Full Panel $789.00**	CYP2C9 w/VKORC1, CYP2C19, CYP2D6, CYP3A4 and CYP3A5, FII and FV and Thrombophilia Risk (MTHFR)
☐**Basic Panel $489.00**	CYP2C9 w/VKORC1, CYP2C19, CYP2D6
☐**Single Test $349.00**	Any Single Test Listed Below (check one box)

Request A Single Test		
☐ CYP2C19 (Plavix)	☐ CYP2C9 w/VKORC1 (Warfarin)	☐FII / FV / MTHFR (Thrombophilia Risk)
☐ CYP2D6 (Beta Blockers)	☐ CYP3A4, ☐CYP 3A5 (Statins)	☐Other _____

Physician Details		Clinic Name	
Last Name		Clinic Address	
First Name		Clinic Phone #	
Professional Registration #		Clinic Fax Number	
PhysicianPhone Number		Clinic Email Address	
Physician Email Address			
Physician Signature (required)	_____		

Patient Details			
Last Name		First Name	
Address		Town/City	
Postal Code		Phone Number	
Date of Birth (DD/MM/YY)		Gender	☐ Male ☐ Female

Medical Information – Patient History, Reason for Ordering Tests / Intended Medications / Comments
Current Medications and other information:

Payment Details			
Credit Card Number		Name on Credit Card	
Expiry Date (MM/YY)		CVV2(3 digit Security)	
Card Type	☐MasterCard	☐Visa	☐Other (please specify):

The patient is responsible for the full cost of the test and authorizes Medicine Match Genetic Testing or an affiliate to charge the above named account for the cost of the physician requested test. If desired, it is the patient's responsibility to request potential reimbursement for the test cost, according to the coverage and procedures that MAY be provided under the patient's private health insurance plan. No reimbursement for the test cost is guaranteed by private health insurance plans.

Genetic Informed Consent: I consent to having genetic analysis performed at the request of my physician and the results of the analysis made available to my physician. My physician to obtain information for therapeutic or diagnostic purposes solely uses my results. This signed request authorizes the requested tests to be completed on my behalf and to disclose the results to my physician. No tests other than those requested by my physician will be performed. The specimen may be used for future testing, as requested by my physician. I permit a copy of this authorization to be used in place of the original.

Patient Signature *(required)*	_____	Date: _____,_____,15	Total Paid $_____

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