quadrant laboratories

TARGETED VARIANT TEST REQUISITION FORM

This form must accompany all specimens

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CLIA #33D2218809

For Quadrant Laboratories Use Only

Accession ID #

Place accession ID sticker here >>>

Date of sample collection

PERSON COMPLETING THE FORM

First and Last Name	**Contact** (phone or email)	**Date of Request** *(MM/DD/YYYY)*

PATIENT INFORMATION (complete form for each person tested)

Legal Last Name	**Legal First Name**
Date of Birth *(MM/DD/YYYY)*	**Biological Sex** ☐ Male ☐ Female

Gender *(if differs from biological sex at birth)* ☐ Male ☐ Female ☐ Non-binary ☐ Self-described

Patient Sample Type

☐ Saliva ☐ Buccal ☐ Whole Blood ☐ Direct Amniotic Fluid ☐ Direct CVS ☐ Other: _____ ☐ Tissue, Source: _____ ☐ Extracted DNA, Source: _____ ☐ Cultured Cells, Source: _____

Has patient been tested before at Quadrant Laboratories? ☐ No ☐ Yes, please provide patient ID # **Date of Collection** *(MM/DD/YYYY)*

Clinical Indication

☐ Diagnostic/Affected ☐ Presymptomatic/At Risk ☐ Carrier Testing/Unaffected

Patient has had a blood transfusion ☐ Yes ☐ No	**Ongoing pregnancy** ☐ Yes ☐ No	**Patient has had an allogenic bone marrow transplant** ☐ Yes ☐ No
Date of Transfusion *(MM/DD/YYYY)*		**Date of Transplant** *(MM/DD/YYYY)*
A wait time of 2-4 weeks is required for some testing.		*Fibroblasts are recommended for patients who had an allogenic bone marrow transplant.*

Has patient's relative been tested before at Quadrant Laboratories? ☐ Yes ☐ No

Full Legal Name	**Date of Birth** *(MM/DD/YYYY)*	**Relationship to Patient**

ICD-10 Codes

(required for insurance billing)

_____

_____

_____

Relevant Clinical Information

We stongly encourge the inclusion of detailed clinical notes or completion of the clinical features checklist and a pedigree. The ability to interpret variants directly correlates with the quality of clinical information provided.

☐ *Clinical records attached*

Patient Last Name:	Patient First Name:	Accession ID #

TESTING MENU - please select test(s) ordered from below menu (REQUIRED)

Family Targeted Variant Testing for pathogenic, likely pathogenic, and most uncertain variants in family members of patients tested at our laboratory. See our Family Targeted Variant Testing Policy on our website for more information.

Positive Control: If the family member was tested at an outside laboratory, we recommend you submit the outside report and a specimen from the individual to serve as a positive control. If a positive control is not provided, negative results will carry a limitation stating Quadrant Laboratories did not have the opportunity to verify that we can detect the variant in this family. Please contact client services with questions.

TEST CODE	GENE(S)	TRANSCRIPT ID (NM:)	VARIANT(S) OR COMMENTS
☐ **QL-1007 (1 variant)**			
☐ **QL-1008 (2 variants)**			
☐ **QL-1009 (3 variants)**			
☐ **QL-1010 (exonic)**			
☐ **Other: _____** *Specify test code*			

SPECIAL INSTRUCTIONS

☐ **No Charge:** *Meets family targeted variant testing policy*

☐ **Positive Control:** *No charge and no report*

☐ **STAT Testing:** *STAT surcharge adds 25% to price. STAT surcharge will not apply if report is delivered after 16 days.*

☐ **Hold Testing:** *waiting on funding approval*

☐ **Hold Testing:** other: _____

☐ **Specimen collected in New York State:** *Include genetic testing healthcare provider statement and NYS non-permitted laboratory test request approval if test is not NY state approved.*

ORDERING PROVIDER/LABORATORY INFORMATION

Clinic Name			**Clinic NPI Number**
Ordering Provider Name (OP)	**OP NPI#**	**Genetic Counselor Name (GC)**	**GC NPI#**
Clinic Street Address		**City**	
State/Province	**Zip/Postal Code**	**Preferred Report Delivery Method** ☐ Fax ☐ Email	
Clinic Phone Number		**Clinic Fax Number**	
Email Address 1 *for report access*		**Email Address 2** *for report access*	

If you require reports to be transmitted via a different secure method, pease specify here:

ORDERING PROVIDER CERTIFICATION

I am authorized by law to order the test(s) requested herein. I certify that this is medically necessary for the diagnosis and detection of a disease/illness/impairment/syndrome/disorder and that the result will be used to inform the patient's medical management and treatment. I authorize such testing for the reasons stated above and have explained it to the parent/guardian who has provided consent (an informed consent form is available, for my convenience). I agree to cooperate with Quadrant Laboratories LLC in providing treatment records for purposes of optimized test interpretation and insurance correspondence, if applicable.

SIGN

Provider Signature of Consent ***(required)*** _____ Date *(MM/DD/YYYY)* _____

Patient Last Name:	Patient First Name:	Accession ID #

SEND OUT LABORATORY complete only if report is needed

Institution/Contact Name			
Street Address	**City**	**State**	**Zip/Postal Code**
Email Address *for report access*	**Phone Number**	**NPI#** *(if applicable)*	

FOR ADDITIONAL ACCESS TO REPORTS *list healthcare providers names and email addresses below*

BILLING SELECTION complete applicable sections

☐ Bill Institution ☐ Bill Patient ☐ Bill Insurance

Institutional Billing Information

Billing Institution		**Contact Name**	
Street Address	**City**	**State**	**Zip/Postal Code**
PO Number		**Billing Account Number**	
Email Address *access to test reports for billing*		**Phone Number**	

Insurance Billing Information

Primary Insurance Carrier		**Insurance Carrier Phone Number**
Policy Holder Name	**Date of Birth** *(MM/DD/YYYY)*	**Relationship to Patient**
Policy ID Number	**Group ID**	

☐ Attach a copy of your insurance card (both sides). If you have a secondary insurance carrier, please attach a copy of that card as well.

☐ Attach a copy of authorization, Quadrant Laboratories must be listed as a servicing provider.

Patient Last Name:	Patient First Name:	Accession ID #

Patient Billing Information - section must be filled out completely

Responsible Party's Name *(must be 18 years or older)*

Street Address	**City**	**State**	**Zip/Postal Code**

Email Address *for report access*	**Phone Number**

Acceptance of financial responsibility for genetic testing

SIGNATURE REQUIRED BELOW TO PROCEED WITH TESTING

MY SIGNATURE INDICATES I ACCEPT FINANCIAL RESPONSIBILITY FOR ALL FEES ASSOCIATED WITH THIS GENETIC TESTING ORDER. If applicable, I authorize Quadrant Laboratories to release information received including, without limitation, medical information, which includes laboratory test results, such as genetic tests results, to my health plan/insurance carrier and its authorized representatives. I further authorize insurance payments directly to Quadrant Laboratories for the services rendered. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity or otherwise. I understand I am financially responsible for fees not paid in full by my insurer, co-payments, and policy deductibles except where my liability is limited by contract or State and Federal law. I agree to help Quadrant Laboratories resolve any insurance claim issues. I understand my out-of-network benefits may apply. Quadrant Laboratories may contact me to resolve any billing-related issues and to request payment.

SIGN _____ _____

Patient/Responsible Party Signature ***(required)*** Date *(MM/DD/YYYY)*

CREDIT CARD PAYMENT

Credit Card Number *(Visa, Discover or Mastercard only)*	**Expiration Date** *(MM/YY)*	**Security Code**

My signature authorizes Quadrant Laboratories to charge my credit card for services for which I am responsible.

SIGN _____ _____

Credit Card Holder's Signature Date *(MM/DD/YYYY)*

Quadrant Laboratories will proceed with testing when:

- Insurance pre-authorizations are received (if applicable)
- Payment options are agreed upon in cases where there is no or partial insurance coverage
    - Before shipping our test kits, Quadrant Laboratories will do a full benefits investigation to determine any out-of-pocket costs
    - Payment for testing is not due until the sample/specimen is received at Quadrant Laborotories