



# GENETIC ASSAYS

A Molecular Diagnostics Laboratory

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www.geneticassays.com

FOR GENETIC ASSAYS USE ONLY	
Accession #:	_____
Date Received:	_____ Time Received: _____
Technician:	_____ Total Volume: _____

## Client Information

Call  Fax Results to \_\_\_\_\_  
at \_\_\_\_\_

## Patient Information – Laboratory

Patient's Name: \_\_\_\_\_  
(Last, First, MI)

Patient's Social Security #: \_\_\_\_\_

Patient/Specimen I.D.#: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Date Drawn: \_\_\_\_\_ Time Drawn: \_\_\_\_\_

# of Tubes: \_\_\_\_\_ Specimen Type: \_\_\_\_\_

Physician: \_\_\_\_\_ NPI#: \_\_\_\_\_

ICD-9 Diagnosis (must be provided): \_\_\_\_\_

## Billing Information

Bill Client Directly  Bill Insurance *Provide info below, or attach copy of insurance card (front **and** back) and demographic sheet.*

Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Other \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**For Medicare and other insured patients:** I authorize any holder of medical or other information about me to release to the health care financing administration or its intermediaries or carriers or any other government agency or insurance carrier responsible for payment, any information needed for this or related Medicare or other claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment shown; **(Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (1) of the Medicare Law. There may be certain molecular genetic tests that are ordered which your physician feels are necessary for the maintenance of good health that are not covered by your insurance contract. You will be expected to pay for those services in full.)** I have read your policy and agree to pay for services not covered by my contract as indicated by my signature. I understand that my doctor has ordered molecular genetic tests to be performed by Genetic Assays, Inc. Laboratory.

Patient's Signature (Required): \_\_\_\_\_ Date: \_\_\_\_\_

## Frequently Requested Assays: *For additional testing needs, please call Client Services.*

- 3701  **Adenovirus** DNA by Real-time PCR (Quantification)
- 3700  **BK Virus** DNA by Real-time PCR (Quantification)
- 3333/0180  **C. trachomatis & N. gonorrhoeae** DNA by PCR (Qualitative)
  - 3333  **Chlamydia trachomatis** DNA by PCR (Qualitative)
  - 0180  **Neisseria gonorrhoeae** DNA by PCR (Qualitative)
- 3702  **Cytomegalovirus (CMV)** DNA by Real-time PCR (Quantification)
- 4025  **Enterovirus** RNA by RT-PCR (Qualitative)
- 6111  **Epstein-Barr Virus (EBV)** DNA by Real-time PCR (Quantification)
- 8191  **H1N1** - Influenza A and 2009 H1N1 by rRT-PCR (Qualitative)
- 750  **HCV** RNA by RT-PCR (Qualitative)
- 219TQ  **HCV** RNA by RT-PCR (Qualitative and Quantification)
  - 8698  Reflex to **HCV Genotyping**
  - 8698  **HCV Genotyping**
- 875TQ  **HIV-1** RNA by RT-PCR (Quantification)
- 7575  **HPV Genotyping**
  - 900  **HSV-1&2** DNA by Real-time PCR (Qualitative)
  - 250  **Mycobacteria** DNA by PCR (Qualitative)
    - 1000  Reflex to **Mycobacteria DNA Sequencing**
  - 275  **Mycobacteria** DNA by PCR w/ **AFB Stain & Culture** (Qualitative)
    - 1000  Reflex to **Mycobacteria DNA Sequencing**
  - 1201  **Respiratory Viral Panel (RVP)** by multiplex RT-PCR (Qualitative)

### Women's Health Care – Commonly Ordered Assays

- 3333/0180  **C. trachomatis & N. gonorrhoeae** DNA by PCR (Qualitative)
  - 3333  **Chlamydia trachomatis** DNA by PCR (Qualitative)
  - 0180  **Neisseria gonorrhoeae** DNA by PCR (Qualitative)
- 395  **HPV** DNA by Hybrid Capture 2 (Qualitative)
  - 7575  Reflex to **HPV Genotyping**
- 395H  **HPV High Risk Only** DNA by Hybrid Capture 2 (Qualitative)
  - 7575  Reflex to **HPV Genotyping**
- 7575  **HPV Genotyping**
- 900  **HSV-1&2** DNA by Real-time PCR (Qualitative)
- 6262  **Cystic Fibrosis Mutation Detection**
  - Racial/Ethnic Background (Required) \_\_\_\_\_
  - Indications for testing (Please check)
    - Diagnostic Testing, diagnosis of CF
    - Carrier Testing, general population of reproductive couples
    - Carrier Testing, positive family history
    - Other: \_\_\_\_\_
  - Does the patient have a positive family history of CF?  Yes  No  Unknown
  - IF YES, please list known mutations: \_\_\_\_\_

Write in test code # and test name below (For additional tests)

\_\_\_\_\_

\_\_\_\_\_