TOXICOLOGY REQUISITION

FAILURE TO COMPLETE ALL FIELDS MAY DELAY PATIENT RESULTS.

iGenomeDx
My DNA My Medicine

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CLIA # 45D2116443 || Lab Director: Manoj Tyagi, PhD, NRCC

Physician Information

Practice Name, Provider(s) Name, Office:

Sample Information

Collection Date & Time:

Sample Collected By:

Sample Type:
- ☐ URINE
- ☐ ORAL SWAB

Requisition Completed By:
for iGenomeDx use

Accession Number:
for iGenomeDx use

Ordering Physician/Authorizing Medical Professional Signature: I hereby authorize testing for this patient. I have provided information regarding molecular testing, and the patient has given consent for testing to be performed. I attest that the ICD-10 Diagnosis Codes provided are accurate records and supported by patients records. I attest that these tests are medically necessary. I hereby authorize iGenomeDx Laboratories to send these patient's test results to the patient's third party payer, if needed, to appeal a denial of reimbursement prior to attempts to obtain reimbursement without the release of patient's results.

PROVIDER'S SIGNATURE

Patient Information

Patient Last Name

Patient First, Middle Name

Date of Birth: (MM/DD/YYYY)

Patient Phone

Patient Gender
- ☐ Female
- ☐ Male
- ☐ Undisclosed

Patient Race
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Native Alaskan
- ☐ Native Hawaiian/Pacific Islander
- ☐ Undisclosed

Patient Ethnicity
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Undisclosed

Patient Address

City, ST Zip

Patient Email:

I authorize iGenomeDx to analyze the specimen provided by me and report the results of such analysis to the ordering physician in conformance with his/her order

PATIENT'S SIGNATURE

Diagnosis (ICD-10 Codes)

Please state why this test constitutes medical necessity for the patient. Reimbursement requires all diagnoses to be coded to a higher degree of specificity.

Billing Information

A photocopy of both sides of Patient's insurance card(s) must be included

- ☐ Medicare
- ☐ Medicaid
- ☐ Commercial
- ☐ Facility Billed

For the patient paid test's facility is advised to collect payment before specimen collection

Insurance	Primary Insurance	Secondary Insurance
Insurance Company Name		
Member ID		
Group Number		
Patient Relationship to Insured		
Claims Address:		
City/State/Zip		

PRESCRIBED MEDICATION *(if Medication List is Available, please attach)*

- ❑ Alprazolam (Xanax)
- ❑ Amitriptyline (Elavil)
- ❑ Amphetamine (Adderall, Vyvanse)
- ❑ Aripiprazole (Abilify)
- ❑ Buprenorphine (Suboxone, Butrans)
- ❑ Bupropion (Wellbutrin)
- ❑ Butalbital (Fioricet)
- ❑ Carbamazepine (Tegretol)
- ❑ Carisoprodol (Soma)
- ❑ Citalopram (Celexa)
- ❑ Clonazepam (Klonopin)
- ❑ Codeine (Tylenol 3)
- ❑ Cyclobenzaprine (Flexeril)
- ❑ Desipramine (Norpramin)
- ❑ Dextromethorphan (Robitussin DM, Delsym)
- ❑ Diazepam (Valium)
- ❑ Doxepin (Silenor)
- ❑ Fentanyl (Duragesic, Actiq)
- ❑ Fluoxetine (Prozac)
- ❑ Gabapentin (Neurontin)
- ❑ Haloperidol (Haldol)
- ❑ Hydrocodone (Vicodin, Norco)
- ❑ Hydromorphone (Dilaudid)
- ❑ Imipramine (Tofranil)
- ❑ Ketamine (Ketalar)
- ❑ Lorazepam (Ativan)
- ❑ Meprobamate (Equanil, Miltown)
- ❑ Methadone (Methadose)
- ❑ Methamphetamine (Desoxyn)
- ❑ Methylphenidate (Ritalin)
- ❑ Morphine (Avinza)
- ❑ Naloxone (Narcan)
- ❑ Naltrexone (Vivitrol)
- ❑ Nortriptyline (Pamelor)
- ❑ Olanzapine (Zyprexa)
- ❑ Oxazepam (Serax)
- ❑ Oxycodone(Oxycontin, Percocet)
- ❑ Oxymorphone (Opana)
- ❑ Paroxetine (Paxil)
- ❑ Phenobarbital (Luminal)
- ❑ Pregabalin (Lyrica)
- ❑ Quetiapine (Seroquel)
- ❑ Sertraline (Zoloft)
- ❑ Tapentadol (Nucynta)
- ❑ Temazepam (Restoril)
- ❑ Tramadol (Ultram)
- ❑ Trazadone (Desyrel)
- ❑ Venlafaxine (Effexor)
- ❑ Zolpidem (Ambien)
- ❑ **NONE**

ORDERED TEST (Please Mark)

Validity Testing: Nitrates, pH, S.G. & Creatinine will be performed on all specimens.

❑ Clinical Drug Screen & Confirmation ❑ Drug Screen Only ❑ Confirmation Only

SCREENING TEST

❑ Buprenorphine ❑ Methadone (EDDP) ❑ Oxycodone ❑ Benzodiazepines ❑ Amphetamine ❑ Cocaine (Benzoylecgonine) ❑ Cannabinoids (THC) ❑ Methamphetamine ❑ Opiates ❑ Barbituates ❑ Heroin (6-AM)

LC/MS CONFIRMATORY TESTING : Please select drugs or panel

Benzodiazepines
- ❑ 7-Aminoclonazepam#
- ❑ Alprazolam
- ❑ a-OH-Alprazolam#
- ❑ Diazepam
- ❑ Lorazepam#
- ❑ Nordiazepam#
- ❑ Oxazepam#
- ❑ Temazepam

Barbiturates
- ❑ Butalbital#
- ❑ Phenobarbital#

Stimulants
- ❑ Amphetamine
- ❑ Methamphetamine
- ❑ Methylphenidate*
- ❑ Ritalinic Acid#

Opiates/Synthetics
- ❑ Codeine
- ❑ Morphine
- ❑ Hydrocodone
- ❑ Hydromorphone
- ❑ Naltrexone*
- ❑ Norhydrocodone#
- ❑ Noroxycodone#
- ❑ Oxycodone
- ❑ Oxymorphone
- ❑ Buprenorphine
- ❑ Norbuprenorphine
- ❑ Fentanyl
- ❑ Norfentanyl#
- ❑ Methadone
- ❑ EDDP
- ❑ Tapentadol
- ❑ N-Desmethyltapentadol#

Opiates/Synthetics (cont...)
- ❑ Tramadol
- ❑ O-Desmethyltramadol#

Anti –Depressants/ Antipsychotic
- ❑ Amitriptyline
- ❑ Nortriptyline#
- ❑ Aripiprazole*
- ❑ Bupropion*
- ❑ Citalopram*
- ❑ Desipramine*
- ❑ Doxepin*
- ❑ Fluoxetine*
- ❑ Haloperidol*
- ❑ Imipramine*
- ❑ Olanzapine*

Anti –Dep/Antipsych (cont...)
- ❑ Paroxetine*
- ❑ Quetiapine*
- ❑ Sertraline*
- ❑ Venlafaxine*

Muscle Relaxers/Sleeping Aids
- ❑ Carisoprodol
- ❑ Carbamazepine*
- ❑ Cyclobenzaprine
- ❑ Gabapentin
- ❑ Ketamine
- ❑ Norketamine#
- ❑ Meprobamate
- ❑ Pregabalin
- ❑ Trazodone*
- ❑ Zolpidem

Illicits/Other
- ❑ 6-Ac-Morphine
- ❑ Benzoylecgonine
- ❑ MDMA
- ❑ Phencyclidine (PCP)
- ❑ THC-COOH#
- ❑ THC*
- ❑ MDA
- ❑ Cocaine*
- ❑ Cotinine*
- ❑ Dextromethorphan*
- ❑ Mitragynine*

#Test available in Urine Specimen
*Test available in Oral Swab

POC RESULTS (Please mark)

	Pos	Neg
AMP		
BAR		
BZO		
COC		
THC		
MTD		
MAMP		
OPI		
OXY		
PCP		
TCA		
Others:		

Please note, Alcohol is not a part of the above panel. If needed, please select from the following:

Alcohol
- ❑ Screening: Ethyl Glucuronide
- ❑ Confirmation: Ethyl Glucuronide, Ethyl Sulfate

ADDITIONAL COMMENTS:

Informed Consent Information

Submission of a requisition for any test listed on this iGenomeDx Requisition form constitutes acknowledgement by the ordering Physician and Patient:

1. This Ordering physician has obtained written informed consent for each test ordered, as required by applicable state and federal laws. A copy of the informed consent is not required by iGenomeDx in order to process a sample, but a copy must be available in the ordering physician's record.
2. The patient has provided written authorization for iGenomeDx to report the results of each test directly to the ordering physician.
3. De-identified samples may be used as blinded validation or as specimen for research and development.
4. All test results will be released directly to the ordering physician, or on their behalf, as state and local laws allow.
5. iGenomeDx is authorized to perform high complexity testing under the Clinical Laboratory Improvement Amendments (CLIA). The results are not intended to be used as the sole means for clinical diagnosis or patient care decisions.
6. The Patient acknowledges their right to obtain a copy of their written report as required by state and federal laws.

Patient Signature:_____ Date:_____