



# TEST REQUISITION

PLEASE PRINT

## Laboratory / Account Information

DATE COLLECTED (required):

TIME COLLECTED:

PATIENT ID#

SENDER SAMPLE ID#

SAMPLE DRAWN AT:  Hospital (Inpatient/Outpatient)  Other

LABORATORY NAME / ADDRESS

PHONE FAX

CONTACT

RESULTS  Mail  Fax  No results to lab

## Patient Information (required)

LAST NAME

FIRST NAME MI

ADDRESS

CITY STATE ZIP

HOME PHONE NUMBER

OTHER PHONE NUMBER

DOB SEX  M  F SSN

## Billing Information (required)

BILL:  Account  Insurance  Laboratory  Patient

Medicare: We will submit claims to Medicare for most of our services, but only for patients who are neither hospital inpatients nor hospital outpatients, for whom the hospital must submit a claim.

**PRIMARY INSURANCE:** As a courtesy, we will bill your insurance. Please attach a copy (front and back) of insurance card(s) and complete all information below. **NOTE: Parent or guardian information required if patient is a minor. Parent or guardian is responsible for payment.**

NAME OF PARENT OR GUARDIAN (IF PATIENT IS UNDER 18 YEARS OF AGE)

INSURANCE CARRIER

POLICY NUMBER

GROUP NAME

GROUP NUMBER

ADDRESS

CITY STATE ZIP

PHONE FAX

POLICYHOLDER NAME

POLICYHOLDER ID# (SSN)

POLICYHOLDER DOB RELATION TO PATIENT

POLICYHOLDER PHONE

**SECONDARY INSURANCE:** As a courtesy, you may also submit secondary insurance information. You must provide a copy (front and back) of your secondary insurance card and provide the following information: secondary insurance carrier, policy number, group name and group number, billing address and phone, policyholder name, ID#, date of birth, relation to patient, and phone number.

**PREAUTHORIZATION INFORMATION:** Enter authorization or referral number(s) for lab services:

## Physician / Account Information

ACCOUNT NAME / ADDRESS

PHONE FAX

PHYSICIAN / NPI#

REFERENCE PHYSICIAN / CC FAX

ICD-9 CODES (required)

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CLINICAL DIAGNOSIS

### CHECK THE APPROPRIATE TEST(S) TO BE PERFORMED (Specimen collection requirements on back)

IBD	<input type="checkbox"/> <b>PROMETHEUS® IBD Serology 7</b> - #1007 Includes 7 tests: ASCA IgA, ASCA IgG, Anti-OmpC IgA, Anti-CBir1, ANCA ELISA, IFA perinuclear pattern, IFA DNase sensitivity <input type="checkbox"/> Add PROMETHEUS® <b>Celiac Serology</b> if PROMETHEUS <b>IBD Serology 7</b> indicates non-IBD <input type="checkbox"/> Add PROMETHEUS® <b>Crohn's Prognostic</b> if PROMETHEUS <b>IBD Serology 7</b> indicates Crohn's Disease ( <b>Requires EDTA/Lavender Top Tube and Serum Tube</b> )
	<input type="checkbox"/> <b>PROMETHEUS® Crohn's Prognostic</b> - #2000* Includes the following: ASCA IgA, ASCA IgG, Anti-OmpC IgA, Anti-CBir1, Anti-I2, IFA perinuclear pattern, IFA DNase sensitivity, NOD2/CARD 15
CELIAC	<input type="checkbox"/> <b>PROMETHEUS® Celiac PLUS</b> - #6301* Includes both antibody and genetic tests with risk stratification • tTg IgA • EMA IgA • Total Serum IgA • AGA IgA • AGA IgG • HLA DQ2/DQ8
	<input type="checkbox"/> <b>PROMETHEUS® Celiac Genetics</b> - #6201 (Genetics only)* Celiac genetic assessment HLA DQ2/DQ8 with risk stratification
	<input type="checkbox"/> <b>PROMETHEUS® Celiac Serology</b> - #1105 (Serology only) includes the following: <input type="checkbox"/> Anti-human tissue transglutaminase (Hu-tTG) IgA recombinant antigen - #1405 <input type="checkbox"/> Anti-endomysial IgA - #1505 <input type="checkbox"/> Total serum IgA - #1605 <input type="checkbox"/> Anti-gliadin IgA - #1205 <input type="checkbox"/> Anti-gliadin IgG - #1305
THIOPURINE MGMT	<input type="checkbox"/> <b>PROMETHEUS® TPMT Genetics</b> - #3300* Genotype patients for individualized starting dose of thiopurines
	<input type="checkbox"/> <b>PROMETHEUS® TPMT Enzyme</b> - #3320 Phenotype patients for individualized starting dose of thiopurines
	<input type="checkbox"/> <b>PROMETHEUS® Thiopurine Metabolites</b> - #3200 Thiopurine metabolite (6-TGN, 6-MMPN) levels Optimize ongoing dosing of thiopurines to reach and maintain therapeutic goal Current therapeutic: <input type="checkbox"/> 6-MP __mg/day <input type="checkbox"/> AZA __mg/day <input type="checkbox"/> Other __mg/day
IBS	<input type="checkbox"/> <b>PROMETHEUS® IBS Diagnostic</b> - #8000 Blood-based biomarker test that aids in the diagnosis of IBS <b>(Serum Separator Tube (SST) only, Spun. Must be shipped refrigerated)</b>
	<input type="checkbox"/> <b>PROMETHEUS® FIBROSpect® II</b> - #4000
ADDITIONAL TESTS	<input type="checkbox"/> <b>PROMETHEUS® Serum Infliximab/HACA Measurement</b> - #3130 <input type="checkbox"/> PROMETHEUS® Serum Infliximab measurement (only) - #3120
	<input type="checkbox"/> <b>PROMETHEUS® LactoTYPE®</b> - #6100*
	<input type="checkbox"/> <b>PROMETHEUS® NOD2/CARD15</b> - #6000*
	<input type="checkbox"/> <b>BreathTek™ UBT</b> - #1202
DOB* Height* Weight*	
*Required for patients < 18 years of age.	

\* My signature below indicates that I have read and understood the entire consent form on the back page.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SPECIMEN COLLECTION AND HANDLING PROCEDURES

The quality of laboratory test results is highly dependent upon proper specimen collection and handling procedures. Listed below are specimen requirements and handling procedures for tests processed by Prometheus Laboratories Inc. **Specimens MUST be labeled with patient name and date of collection. Unlabeled specimens will not be accepted for testing.**

Test Ordered (Turnaround Time* From Date of Receipt)	Transportation Kit Requirements	Type of Specimen Required	Tube for Specimen Collection	Recommended Specimen Volume**	Storage Conditions	Stability of Specimen
<b>PROMETHEUS® IBD Serology 7 (3-4 days)</b> <b>PROMETHEUS® Celiac Serology (2-3 days)</b> <b>PROMETHEUS® Serum Infiximab/HACA Measurement (7 days)</b> <b>PROMETHEUS® FIBROSpect® II (4 days)</b>	Cold pack acceptable but not required	SERUM†	Serum Separator Tube or <b>Red Top Tube</b>	2.0 mL (0.50 mL for Peds)	Room Temperature or Refrigerate	Serum is stable for 7 days at room temp
<b>PROMETHEUS® Crohn's Prognostic (4-7 days)</b>	Cold pack acceptable but not required	SERUM† AND EDTA WHOLE BLOOD Specimens must be shipped together in same box	<b>EDTA/Lavender Top Tube AND Serum Separator Tube/ Red Top Tube</b>	2.0 mL Serum <b>AND</b> 5.0 mL Whole Blood	Refrigerate- <b>DO NOT FREEZE SPECIMEN</b>	Shipment within 7 days of collection and storage at or below room temp is recommended
<b>PROMETHEUS® Celiac PLUS (PROMETHEUS Celiac Serology and PROMETHEUS Celiac Genetics) (3 days)</b>	Cold pack acceptable but not required	SERUM† AND EDTA WHOLE BLOOD Specimens must be shipped together in same box	<b>EDTA/Lavender Top Tube AND Serum Separator Tube/ Red Top Tube</b>	2.0 mL Serum <b>AND</b> 5.0 mL Whole Blood	Room Temperature or Refrigerate	Shipment within 7 days of collection and storage at or below room temp is recommended
<b>PROMETHEUS® TPMT Genetics (2 days)</b> <b>PROMETHEUS® LactoTYPE® (7 days)</b> <b>PROMETHEUS® Celiac Genetics (3 days)</b> <b>PROMETHEUS® NOD2/CARD15 (7 days)</b>	Cold pack acceptable but not required	EDTA WHOLE BLOOD	<b>EDTA/Lavender Top Tube</b>	5.0 mL Whole Blood	Refrigerate- <b>DO NOT FREEZE SPECIMEN</b>	Shipment within 7 days of collection and storage at or below room temp is recommended
<b>PROMETHEUS® Thiopurine Metabolites (3 days)</b> <b>PROMETHEUS® TPMT Enzyme (3 days)</b>	This blood <b>MUST</b> be kept cool: ship with cold packs only	EDTA WHOLE BLOOD	<b>EDTA/Lavender Top Tube</b>	5.0 mL Whole Blood	Refrigerate- <b>DO NOT FREEZE SPECIMEN</b>	Stable for 7 days refrigerated or maximum 24 hours at room temp
<b>PROMETHEUS® IBS Diagnostic (7 days)</b>	This blood <b>MUST</b> be kept cool: ship with cold packs only	SERUM†	<b>Serum Separator Tube (SST) only, spun</b>	2.0 mL	Refrigerate	Stable for 7 days refrigerated
<b>BreathTek™ UBT (2 days)</b>	BreathTek Kit	Follow kit instructions	Bags provided in kits <b>FIRMLY</b> secure white cap	10 sec breathing per bag	Room Temperature (15-30°C)	7 days at room temp (15-30°C)

\*Business days

\*\*Note: Minimum specimen volume for genetic testing may vary with the WBC count.

†Serum: Internal studies have shown that one freeze-thaw cycle does not affect results; however, multiple freeze-thaw cycles are not recommended.

## INFORMED CONSENT FOR GENETIC TESTING

I request and authorize Prometheus to test my/my child's genetic specimen for the test specified on the attached test requisition. The purpose of this test is to determine if I/my child may have a mutation in the gene(s) being tested, which has been found to be associated with this condition. I understand that this test will only test for this specific condition; it will not detect ALL possible mutations within this gene, nor will it detect mutations in other genes.

My doctor has discussed the genetic test ordered and has described the steps involved in the test, the constraints of the procedure, and its accuracy. I have been advised of the risks and benefits of genetic testing. The significance of a positive and a negative test result has been explained to me by a qualified medical professional. I understand that a positive test result is an indication that I may be predisposed to, or have, the condition listed above. If the results are positive, I understand that I may wish to consider further independent testing, consult my physician, or pursue genetic counseling. I understand that the test may fail, that the results may be non-informative or not predictive for my case, and that these tests may reveal information that is unrelated to their intended purpose.

Genetic testing offered at Prometheus is completely voluntary and is used to predict response to specific therapeutics and/or to provide information to aid in the treatment of gastrointestinal ailments. No unauthorized testing is performed on the specimens. I authorize Prometheus to report my test results directly to the ordering physician. The genetic specimens will be destroyed within 60 days of test completion. This consent does not authorize the use or release of any other medical information unrelated to this genetic test.

I understand that I may seek professional genetic counseling prior to signing this informed consent and undergoing the testing procedure, and I have received written information identifying a genetic counselor or medical geneticist by my treating physician.

**SHIPPING INSTRUCTIONS:** Prometheus has an agreement with FedEx Express® for priority overnight delivery service within the United States and Canada. Please call FedEx to schedule a pickup at 1-800-GoFedEx (463-3339). FedEx will pick up your specimens and ship them to Prometheus in San Diego at no expense to you. Prometheus will provide specimen transportation kits upon request.

**NOTE:** Multiple specimens may be shipped in a single transportation kit.

**For more information, call Client Services: (888) 423-5227 or go to [www.prometheuslabs.com](http://www.prometheuslabs.com)**

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