



TEST REQUISITION

PLEASE PRINT

Laboratory / Account Information

DATE COLLECTED (required): _____

TIME COLLECTED: _____

PATIENT ID# _____

SENDER SAMPLE ID# _____

SAMPLE DRAWN AT: Hospital Inpatient Hospital 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. Medicare requires the signature of the ordering physician for all clinical laboratory tests.

I certify that the ordered test(s) is(are) reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition.

Ordering Physician's Signature _____ Date _____

Print Name _____

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: Attach a copy (front and back) of the secondary insurance card. Provide the insurance name, policy number and group name, billing address and phone, policyholder name, ID#, date of birth, relation to patient, and phone number.

PREAUTH/REFERENCE #: _____

Physician / Account Information

ACCOUNT NAME / ADDRESS _____

PHONE _____

FAX _____

PHYSICIAN / NPI# _____

ICD-9 CODES (required)

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CLINICAL DIAGNOSIS _____

PROMETHEUS TESTING ONLY. NO SUBSTITUTIONS.†

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

IBD	<input type="checkbox"/> PROMETHEUS[®] IBD Serology 7 - #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 [®] Celiac Serology if PROMETHEUS IBD Serology 7 indicates non-IBD <input type="checkbox"/> Add PROMETHEUS [®] Crohn's Prognostic if PROMETHEUS IBD Serology 7 indicates Crohn's Disease (Requires EDTA/Lavender Top Tube and Serum Tube)
	<input type="checkbox"/> PROMETHEUS[®] Crohn's Prognostic - #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"/> PROMETHEUS[®] Celiac PLUS - #6355* Includes both antibody and genetic tests with risk stratification • tTg IgA • EMA IgA • Total Serum IgA • DGP IgA • DGP IgG • HLA DQ2/DQ8
	<input type="checkbox"/> PROMETHEUS[®] Celiac Genetics - #6201 (Genetics only)* Celiac genetic assessment HLA DQ2/DQ8 with risk stratification <input type="checkbox"/> PROMETHEUS[®] Celiac Serology - #1155 (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"/> DGP Antibody IgA - #1255 <input type="checkbox"/> DGP Antibody IgG - #1355
THIOPURINE MGMT	<input type="checkbox"/> PROMETHEUS[®] TPMT Genetics - #3300* Genotype patients for individualized starting dose of thiopurines
	<input type="checkbox"/> PROMETHEUS[®] TPMT Enzyme - #3320 Phenotype patients for individualized starting dose of thiopurines
	<input type="checkbox"/> PROMETHEUS[®] Thiopurine Metabolites - #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
ADDITIONAL TESTS	<input type="checkbox"/> PROMETHEUS[®] FIBROSpect[®] II - #4000
	<input type="checkbox"/> PROMETHEUS[®] Serum Infliximab/HACA Measurement - #3130 <input type="checkbox"/> PROMETHEUS [®] Serum Infliximab measurement (only) - #3120
	<input type="checkbox"/> PROMETHEUS[®] LactoTYPE[®] - #6100* <input type="checkbox"/> Other Prometheus Tests _____

†By using the Prometheus test requisition, you are specifically requesting that your patient's specimen be sent to Prometheus for testing and asking that no alternative test be performed.

GENETIC CONSENT

*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: _____

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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
PROMETHEUS[®] IBD Serology 7 (3-4 days) PROMETHEUS[®] Celiac Serology (2-3 days) PROMETHEUS[®] Serum Infliximab/HACA Measurement (7 days) PROMETHEUS[®] FIBROSpect[®] II (4 days)	Cold pack acceptable but not required	SERUM [†]	Serum Separator Tube or Red Top Tube	2.0 mL (0.50 mL for Peds)	Room Temperature or Refrigerate	Serum is stable for 7 days at room temp
PROMETHEUS[®] Crohn's Prognostic (4-7 days)	Cold pack acceptable but not required	SERUM [†] AND EDTA WHOLE BLOOD Specimens must be shipped together in same box	EDTA/Lavender Top Tube AND Serum Separator Tube/ Red Top Tube	2.0 mL Serum AND 5.0 mL Whole Blood	Refrigerate- DO NOT FREEZE SPECIMEN	Shipment within 7 days of collection and storage at or below room temp is recommended
PROMETHEUS[®] Celiac PLUS (PROMETHEUS Celiac Serology and PROMETHEUS Celiac Genetics) (3 days)	Cold pack acceptable but not required	SERUM [†] AND EDTA WHOLE BLOOD Specimens must be shipped together in same box	EDTA/Lavender Top Tube AND Serum Separator Tube/ Red Top Tube	2.0 mL Serum AND 5.0 mL Whole Blood	Room Temperature or Refrigerate	Shipment within 7 days of collection and storage at or below room temp is recommended
PROMETHEUS[®] TPMT Genetics (2 days) PROMETHEUS[®] LactoTYPE[®] (7 days) PROMETHEUS[®] Celiac Genetics (3 days)	Cold pack acceptable but not required	EDTA WHOLE BLOOD	EDTA/Lavender Top Tube	5.0 mL Whole Blood	Refrigerate- DO NOT FREEZE SPECIMEN	Shipment within 7 days of collection and storage at or below room temp is recommended
PROMETHEUS[®] Thiopurine Metabolites (3 days) PROMETHEUS[®] TPMT Enzyme (3 days)	MUST be kept cool: ship with cold packs only	EDTA WHOLE BLOOD	EDTA/Lavender Top Tube	5.0 mL Whole Blood	Refrigerate- DO NOT FREEZE SPECIMEN	Stable for 7 days refrigerated or maximum 24 hours at room temp

*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