

TEST REQUISITION

PLEASE PRINT

SAMPLE COLLECTION INFORMATION

DATE COLLECTED (required): _____

TIME COLLECTED: _____

PATIENT ID #: _____

SENDER SAMPLE ID #: _____

MEDICARE ONLY - HOSPITAL STATUS WHEN SAMPLE WAS COLLECTED:

Hospital inpatient Hospital outpatient Non-hospital patient

LABORATORY/OTHER NAME/ADDRESS: _____

PHONE #: _____ FAX #: _____

CONTACT: _____

RESULTS: Mail Fax No results to lab

PATIENT INFORMATION (REQUIRED)

LAST NAME: _____

FIRST NAME: _____ MI: _____

ADDRESS: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____

OTHER PHONE #: _____

DOB: _____ SEX: M F SSN: _____

ACKNOWLEDGMENT OF INFORMED CONSENT FOR GENETIC TESTING

My signature below indicates that I have read and understand the genetic consent requirement for my patient on the back page and acknowledge that I have obtained the appropriate consent.

Provider signature: _____ Date: _____

BILLING INFORMATION (REQUIRED)

BILL: Provider 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.

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 PROVIDER'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 is 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 #: _____

GROUP NAME: _____ GROUP #: _____

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 #: _____

PROVIDER/ACCOUNT INFORMATION

ACCOUNT NAME/ADDRESS: _____

PHONE #: _____

FAX #: _____

PROVIDER/NPI#: _____

ICD CODE(S) (required):

CLINICAL DIAGNOSIS: _____

PROMETHEUS TESTING ONLY. NO SUBSTITUTIONS.†

SELECT THE APPROPRIATE TEST TO BE PERFORMED

CHECK BOX ON LEFT NEXT TO TEST BEING ORDERED.
SPECIMEN COLLECTION REQUIREMENTS ON BACK.

PROMETHEUS[®] IBD sgi Diagnostic[®] - #1800*
Requires EDTA/Lavender-Top Tube and Serum Tube

Add-on options—if IBD sgi Diagnostic indicates Crohn's disease
(By selecting ADD options below, you are ordering PROMETHEUS IBD sgi and a conditional add-on test order.)

ADD PROMETHEUS[®] Monitr[™] Crohn's Disease - #7300

ADD PROMETHEUS[®] Crohn's Prognostic - #2001*

IBD

PROMETHEUS[®] Monitr[™] Crohn's Disease - #7300

13 biomarkers to assess mucosal healing in Crohn's disease patients
(I acknowledge this patient has Crohn's disease.)

Medication: _____ Dose: _____

Date: _____ Frequency: _____

New

PROMETHEUS[®] Crohn's Prognostic - #2001*

PROMETHEUS[®] Celiac PLUS - #6360*

PROMETHEUS[®] Celiac Genetics - #6260 (Genetics only)*

PROMETHEUS[®] Celiac Serology - #1155 (Serology only)

Includes the following:

Tissue transglutaminase (tTG) IgA recombinant antigen - #1405
 Anti-endomysial (EMA) IgA - #1505 Total serum IgA - #1605
 DGP IgA - #1255 DGP IgG - #1355

CELIAC

PROMETHEUS[®] TPMT Genetics - #3300*

PROMETHEUS[®] TPMT Enzyme - #3320

PROMETHEUS[®] Thiopurine Metabolites - #3200

Current therapeutic:

6-MP _____ mg/day AZA _____ mg/day Other _____ mg/day

THIOPURINE MGMT

PROMETHEUS[®] FIBROSpect[®] HCV - #4000

Assessment of liver fibrosis severity for HCV patients

New

PROMETHEUS[®] FIBROSpect[®] NASH - #4100

Assessment of liver fibrosis severity for NASH patients

New

ADD'L TESTS

PROMETHEUS[®] LactoTYPE[®] - #6100*

Other Prometheus test(s): _____

*ACKNOWLEDGMENT OF INFORMED GENETIC CONSENT.

†By using this 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.

SPECIMEN COLLECTION AND HANDLING PROCEDURES

Test Ordered (Turnaround Time From Date of Receipt)*	Specimen Requirements	Recommended Specimen Volume**	Specimen Storage/Stability***	Transportation Kit Requirement
PROMETHEUS® IBD sgi Diagnostic® (3-4 days)	SERUM AND WHOLE BLOOD in Serum Separator or Red-Top Tube AND EDTA/Lavender-Top Tube	2.0 mL serum AND 2.0 mL whole blood	Room temp: 7 days Refrigerated: 21 days	Refrigerated preferred, ship with cold pack
PROMETHEUS® Monitr™ Crohn's Disease (3 days)	SERUM in Serum Separator or Red-Top Tube	2.0 mL serum	Room temp: 24 hours Refrigerated: 7 days	Refrigerated preferred, ship with cold pack
PROMETHEUS® Crohn's Prognostic (4-7 days)	SERUM AND WHOLE BLOOD in Serum Separator or Red-Top Tube AND EDTA/Lavender-Top Tube	2.0 mL serum AND 2.0 mL whole blood	Room temp: 7 days Refrigerated: 7 days	Ambient or cold pack acceptable
PROMETHEUS® Celiac PLUS (PROMETHEUS Celiac Genetics and PROMETHEUS Celiac Serology) (3 days)	SERUM AND WHOLE BLOOD in Serum Separator or Red-Top Tube AND EDTA/Lavender-Top Tube	2.0 mL serum AND 2.0 mL whole blood	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
PROMETHEUS® Celiac Genetics (2-3 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	2.0 mL whole blood	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
PROMETHEUS® Celiac Serology (2-3 days)	SERUM in Serum Separator or Red-Top Tube	2.0 mL serum (0.5 mL for peds)	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
PROMETHEUS® TPMT Genetics (2 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	2.0 mL whole blood	Room temp: 10 days Refrigerated: 30 days	Ambient or cold pack acceptable
PROMETHEUS® TPMT Enzyme (3 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	5.0 mL whole blood	Room temp: 24 hours Refrigerated: 8 days	Refrigerated preferred, ship with cold pack
PROMETHEUS® Thiopurine Metabolites (3 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	5.0 mL whole blood	Room temp: 3 days Refrigerated: 8 days	Refrigerated preferred, ship with cold pack
PROMETHEUS® FIBROSpect® HCV PROMETHEUS® FIBROSpect® NASH (4 days)	SERUM in Serum Separator or Red-Top Tube	2.0 mL serum (0.5 mL for peds)	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
PROMETHEUS® LactoTYPE® (7 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	2.0 mL whole blood	Room temp: 10 days Refrigerated: 30 days	Ambient or cold pack acceptable

*Business days.

**Note: Minimum specimen volume for genetic testing may vary with the white blood cell count.

***Frozen stability data may be available. Contact Client Services if detailed information is needed.

Specimens should be labeled with 2 identifiers and date of collection. Examples of acceptable identifiers include, but are not limited to patient name, date of birth, hospital number, requisition, accession, or unique random number. Unlabeled specimens will not be accepted for testing.

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 Laboratories Inc. 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 at 888-423-5227 or go to www.prometheuslabs.com.

ACKNOWLEDGMENT OF INFORMED CONSENT FOR GENETIC TESTING

I warrant that this test was ordered and that I have obtained the appropriate prior written consent. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person) and includes the following (unless certain of the following information is not required by the state in which I practice):

- a statement that the purpose of this test is to determine if the patient may have a variant in the gene(s) being tested, which has been found to be associated with this condition;
- a statement that this test will only test for this specific condition and will not detect ALL possible variants within this gene, nor will it detect variants in other genes;
- a statement that prior to signing the written consent a qualified medical professional discussed with the patient the genetic test ordered and described the steps involved in the test, the constraints of the procedure, and its accuracy;
- a statement that the patient was advised by a qualified medical professional of the risks and benefits of genetic testing and advised of the significance of a positive and a negative test result;
- a statement that the patient understands that a positive test result is an indication that the patient may be predisposed to, or have, the condition listed above;
- a statement that, if the results are positive, the patient understands that he/she may wish to consider further independent testing, consult his/her provider, or pursue genetic counseling;
- a statement that the patient understands that the test may fail, that the results may be noninformative or not predictive for his/her case, and that these tests may reveal information that is unrelated to their intended purpose;
- a statement that the patient understands that 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 and that no unauthorized testing is performed on the specimens;
- a statement authorizing Prometheus to report his/her test results directly to the ordering provider;
- a statement acknowledging that the genetic specimens will be destroyed within 60 days of test completion;
- a statement that the written consent does not authorize the use or release of any other medical information unrelated to this genetic test; and
- a statement that the patient understood that he/she could seek professional genetic counseling prior to signing this informed consent and undergoing the testing procedure and received written information identifying a genetic counselor or medical geneticist by his/her treating provider.

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