

FOR GEM LABS USE ONLY:

Date Received: _____
Sample Type: _____
Other: _____

PATIENT INFORMATION

Name (Last, First, MI) _____
Address: _____
City, State, Zip: _____
Sex: **Male** **Female** Pregnant: **Y / N**

DOB: ____/____/____
Phone: _____
SS #: ____-____-____
Ethnicity: _____

REFERRING PHYSICIAN/INSTITUTION

Name: _____
Hospital/Institution: _____
Address: _____
City, State, Zip: _____
Name & Phone of person completing requisition: _____

Phone: _____
Fax: _____
E-mail: _____

Sign: _____

BILLING INFORMATION

**Please complete all the information asked in this section, the referring physician or referring institution would be billed if needed information were incomplete.*

Bill: Patient Insurance Referring Institution Check/Money Order enclosed for \$ _____
Relation: Spouse Self Dependant

Please fill out any of the selected option described below:

Credit Card Information:

Name (as appears on Card): _____
Account #: _____ Exp. Date: _____

Client (Account):

Name: _____
Hospital/Institution: _____
Address: _____
City, State, Zip: _____

Account #: _____
Phone: _____
Fax: _____

Insurance/Medicare/Medicaid Information: **Please provide a copy of the front and back of the patient's insurance card (Required)*

Name: _____ DOB: ____/____/____ SSN#: ____-____-____
Relationship to Patient: _____ Authorization #: _____ Gender: **M F**
Insurance Name: _____ Insurance Phone # _____
Insurance Address: _____ City, State, Zip: _____
Group Plan # _____ Policy ID # _____ Medicare or Medicaid ID # _____

I authorize any holder of medical information about me to release to any insurance carrier any information needed for this claim. I permit a copy of this authorization to be used in place of the original and request that the payment of medical insurance is paid to Georgia Esoteric and molecular Diagnostic Labs LLC. I also understand that I will be held responsible for any portion of the claim that the insurance company does not pay.

Sign: _____ Date: _____

SAMPLE INFORMATION

EDTA Blood Plasma Serum
DNA Tissue Other

Collection Date: _____
Sample Stored at: _____

MOLECULAR TESTS

- Factor V Leiden Mutation (1061)
- Factor II (Prothrombin) Mutation (1062)
- HIV-1 Genotyping for Drug Resistance (1081)
- HIV-1 Viral Load – Ultrasensitive (1083)
(Detection Range: 20-10,000,000 copies/mL)
- HIV-1 Virtual Phenotype (1085)
- Cystic Fibrosis Testing (32 Mutations) (1031)
 - Patient/Couple is pregnant
 - No family history of CF
 - Family history of CF
 - Diagnosis of a suspected patient
 - Absence of vas deferens
 - Abnormal ultrasound
 - Other infertility
- P450 AmpliChip – blood sample (1161)
- P450 AmpliChip – saliva sample (1162)