GENinCode

CARDIOVASCULAR TEST REQUISITION FORM

THIS FORM MUST ACCOMPANY ALL SPECIMENS

ORDERING PROVIDER INFORMATION

Account name/number : _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Ordering Provider: _____ NPI: _____ Email: _____

ADDITIONAL RESULTS RECIPIENTS

Genetic Counselor/Other Medical Provider: _____ Phone/Fax/Email: _____

Genetic Counselor/Other Medical Provider: _____ Phone/Fax/Email: _____

Genetic Counselor/Other Medical Provider: _____ Phone/Fax/Email: _____

SPECIMEN INFORMATION

Sample Code *(from barcode in test kit)* : _____

Sample type: ☐ Blood ☐ Buccal Swab ☐ Saliva Collection Date *(mm/dd/yyyy)*: _____

Ship a buccal swab kit to this patient *(optional)*: ☐ No ☐ Yes, to address above ☐ Yes, to alternate address: _____

_____

TEST SELECTION

☐ LIPID inCode — Hyperlipidemia assessment including 6-gene Familial Hypercholesterolemia panel (*LDLR, APOB, PCSK9, APOE, LDL-RAP1, LIPA*) + Genetic Risk Score (GRS) for hyperlipidemia + Genetic Risk Score (GRS) for coronary artery disease.

☐ LIPID inCode FAMILY MEMBER CASCADE TEST — Please attach the index case test result report, and/or indicate the index cases's GEN inCode Accession Number: _____

☐ CARDIO inCode-Score — Genetic Risk Score (GRS) for coronary artery disease

CONSENT & AUTHORIZATION

By signing this requisition form, I acknowledge that the patient (or authorized individual) has been informed and consented to this genetic testing being performed. I acknowledge that the patient has agreed that i) GEN inCode US Inc. and its designees may release information concerning testing to the patient's insurer (if billing to insurance) ii) if the patient's insurer does not reimburse GEN inCode US Inc. in full for any reason then GEN inCode US Inc. may bill the patient for the services and the patient will remit payment to GEN inCode Inc. and iii) for amounts the patient receives from the insurer, patient will remit payment to GEN inCode US Inc. for services rendered. I confirm that I am authorized under applicable law to order this test. I consent and direct GEN inCode US Inc. to share my contact information with third parties who may contact me directly in connection with patient results. I acknowledge that the patient has agreed that their de-identified data and samples may be used for i) internal quality control and optimization processes, ii) research completed internally to make new discoveries, iii) research completed in collaboration with external parties. The patient has been informed that they can opt-out of having their de-identified information included in these efforts by reaching out to customerservice-US@genincode.com at any time.

Medical professional or delegate Signature *(required)*: _____ **Date** *(mm/dd/yy)*: _____

GENinCode

Customer Service
customerservice-US@genincode.com
P : (949)930-0462 **F** : (949)271-4518

GEN inCode US Inc.
Clinical Laboratory, CLIA number 05D2272929
5 Mason Ln, Suite 200, Irvine, CA 92618