GENinCode

CARDIOVASCULAR TEST REQUISITION FORM

THIS FORM MUST ACCOMPANY ALL SPECIMENS

First Name:
Last Name:
Date of (MM/DD/
Patient I
PLACE STICKER HERE
Collection Date: (MM/DD/YYYY)
GENinCode

PATIENT INFORMATION

First name: _____ MI: _____ Last name: _____

Date of birth *(mm/dd/yyyy)*: _____ Patient ID (MRN): _____ Sex assigned at birth: ☐ Female ☐ Male

Race/Ethnicity *(select all that apply)*:
☐ Ashkenazi Jewish ☐ Asian ☐ Black ☐ French Canadian ☐ Hispanic
☐ Native American ☐ Pacific Islander ☐ Sephardic Jewish ☐ White ☐ Other _____

Email Address: _____

Mobile Phone: (patient consents to receive texts from GEN inCode) _____

Address: _____

City: _____ State: _____ Zip: _____

INDICATIONS FOR TESTING (CHECK ALL THAT APPLY): Complete this **required** clinical information checklist and attach a clinic note.
IMPORTANT: Clinical information is essential for insurance billing and variant interpretation.

- ☐ **E78.01** Familial hypercholesterolemia
- ☐ **Z83.42** Family history of familial hypercholesterolemia
- ☐ **Z84.81** Family history of known gene mutation
  Index case information: Gene/Variant found: _____
  Name: _____ DOB: _____
  Relationship to individual being tested: _____
- ☐ **E78.0** Pure hypercholesterolemia
  Highest LDL-C level: _____ Age at testing: _____
- ☐ **E78.5** Hyperlipidemia, unspecified
  Highest LDL-C level: _____ Age at testing: _____
- ☐ **E78.2** Mixed hyperlipidemia
- ☐ **E78.1** Pure hypertriglyceridemia
- ☐ Corneal arcus
- ☐ Xanthomatosis
- ☐ **I25.1** Atherosclerotic heart disease
- ☐ **I25.2** Previous MI
  Number of events: _____ Age at first event: _____
- ☐ **Z86.73** Prior stroke
  Number of events: _____ Age at first event: _____
- ☐ **Z82.3** Family history of stroke
- ☐ **Z82.49** Family history of ischemic heart disease
- ☐ Other: _____

PERSONAL HISTORY

Is/was this patient affected/symptomatic? ◯ Yes ◯ No
If yes, briefly describe history and attach clinical notes:

FAMILY HISTORY

Is there a family history of cardiovascular disease? ◯ Yes ◯ No
If yes, briefly describe and attach pedigree and/or clinical notes:

BILLING INFORMATION

BILLING SELECTION (select one):

- ☐ **Insurance**
- ☐ **Institutional**
  Contact Name (required):
  Contact Phone (required):
- ☐ **Patient pay**
  Patient email required:

INSURANCE INFORMATION (Provide only if applicable. Attach front and back of insurance card, clinical notes and medical records.)

Policyholder Name: _____ Primary Insurance Company Name: _____

Member ID#: _____ Insurance Phone#: _____

Relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____ Prior Authorization#: _____

Please provide secondary insurance name/ID/Phone# if available: _____

Medicare insurance billing only (select one):
- ☐ Patient was treated as a hospital inpatient (more than 24hr stay) in the last 14 days
- ☐ Not a hospital patient

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ORDERING PROVIDER INFORMATION

Account name/number : _____ Phone: _____

Address : _____ Fax: _____

City: _____ State: _____ Zip: _____

Ordering Provider: _____ NPI: _____ Email: _____

ADDITIONAL RESULTS RECIPIENTS

Primary Clinical Contact Name: _____ Phone/Fax/Email: _____
(if different than ordering provider)

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

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

SPECIMEN INFORMATION

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

Ship a buccal swab kit to this patient *(NO P.O. BOX, PHYSICAL ADDRESS ONLY)*: ☐ No ☐ Yes, to address above ☐ Yes, to alternate address: _____

TEST SELECTION

☐ LIPID inCode — Monogenic Familial Hypercholesterolmia analysis, 6-gene panel *(LDLR, APOB, PCSK9, APOE, LDLRAP1, LIPA)*
- ☐ Opt-in for Subsequent Genetic Risk Score (GRS) for hypercholesterolemia
- ☐ Opt-in for Subsequent Genetic Risk Score (GRS) for coronary artery disease

☐ 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.

For NY Residents ☐ I am a New York resident and I give GEN inCode US Inc. permission to store my sample for longer than 60 days. NOTE: If left blank, consent is interpreted as "NO".

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

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