Prometheus Laboratories

CONFIDENTIAL

Please fill in, sign and fax to 877-816-4019 **Date: ____/____/____**

General Add-On Test Request Form

Use this form to request additional testing for specimens already in-house at Prometheus Laboratories. This information is intended for the recipient only. Please destroy if received in error and notify the sender. The recipient secures this information in accordance with HIPAA regulations.

Ordering Lab / Physician _____ **Office Phone Number** _____ **Contact Person** _____

Patient Name (Last, First) _____ **Patient / Accession ID #** _____ **Date of Birth** _____ **Original Order Date** _____

Clinical Diagnosis / ICD-10 Code(s): _____

Please check the Prometheus test(s) to be performed

- ☐ **Anser® ADA** (#3170)
- ☐ **Anser® IFX** (#3150)
- ☐ **Anser® RZB** (#3140)
- ☐ **Anser® VDZ** (#3180)
- ☐ **Anser® UST** (#3190)
- ☐ **IBD Precis®** (#1810)
- ☐ **Respondr® TNF*** (#4200) (patient weight: _____ kg)
- ☐ **RiskImmune®*** (#3600)
- ☐ **TPMT Genetics*** (#3300)
- ☐ **TPMT Enzyme** (#3320)
- ☐ **Thiopurine Metabolites** (#3200)
- ☐ **Celiac PLUS*** (serology & HLA-DQ2/DQ8) (#6360)
- ☐ **Celiac Genetics*** (HLA-DQ2/DQ8) (#6260)
- ☐ **Celiac Serology** (#1155)
- ☐ **FibroSpect® HCV** (#4000)
- ☐ **FibroSpect® NASH** (#4100)

***Signature required for acknowledgment of informed consent for genetic testing.**
Note: Add-on testing may require additional authorization from a referral laboratory and is contingent upon specimen volume and sample stability. PredictrPK® is available as an add-on test using the PredictrPK Add-On Test form, which collects required details such as patient weight & treatment inputs.

Acknowledgement 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 that the following information is not required by the state in which I practice):

1. 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.
2. 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.
3. Prior to my signature of the written consent, a qualified healthcare 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.
4. My patient was advised by a qualified healthcare professional of the risks and benefits of genetic testing, and advised of the significance of a positive and negative result.
5. The patient understands that a positive test result is an indication that the patient may be predisposed to, or have, the condition listed.
6. The patient understands that the test may fail, that the results may be non-informative or not predictive for his/her case, and that the test may reveal information that is unrelated to their intended purpose.
7. No unauthorized test is performed on specimens.
8. NY-State specimens will be destroyed within 60 days after collection when no longer required for clinical purposes.
9. The informed consent does not authorize the use or release of any other identified medical information unrelated to this genetic test.
10. The patient understood that he/she could see professional genetic counseling prior to undergoing the testing procedure and received written information identifying a genetic counselor or medical geneticist by his/her treating provider.

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

Provider Signature: _____ Date: _____