CIRCULOGENE

RECEIVED DATE _____ RECEIVED BY _____

REV 1/12/2022

Client Services: 855-380-1555
Fax: 855-614-7084
support@circulogene.com

Somatic and Hereditary

1. PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

MR# _____

DOB _____ ☐ MALE ☐ FEMALE

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE _____

2. SPECIMEN INFORMATION

COLLECTION DATE _____ ☐ HOME PHLEBOTOMY REQUESTED

3. DIAGNOSIS INFORMATION

DIAGNOSIS _____ ICD-10 CODE(S) _____

INDICATION:

☐ LUNG ☐ COLORECTAL ☐ PANCREATIC ☐ BREAST
☐ OVARIAN ☐ GIST ☐ LIVER ☐ PROSTATE
☐ CERVICAL ☐ GASTRIC ☐ BILIARY ☐ BLADDER
☐ ENDOMETRIAL ☐ ESOPHAGEAL ☐ THYROID ☐ MELANOMA
☐ OTHER/UNSPECIFIED

4. CLIENT INFORMATION / ORDERING PHYSICIAN

CLIENT ID _____ NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

INDICATE ORDERING PHYSICIAN: _____

☐ OTHER _____ IF OTHER, NPI # _____

REFERRING PHYSICIAN NAME: _____

REFERRING PHYSICIAN FAX: _____

5. BILLING INFORMATION **INCLUDE COPY OF INSURANCE CARD & I.D.**

☐ ATTACH FACE SHEET WITH PATIENT INSURANCE INFORMATION
OR COMPLETE INSURANCE INFORMATION ON BACK OF THIS FORM

☐ ATTACH COPY FRONT AND BACK OF INSURANCE CARD(S) IF POSSIBLE

CANCER TUMOR PROFILES:

*Visit www.circulogene.com/tests for a full list of all somatic and hereditary genes

☐ SOMATIC MOLECULAR PANEL

NGS GENE PANEL*
(BRCA1, BRCA2 INCLUDED)
PD-L1 EXPRESSION
MSI
ALK GENE FUSION
ROS1 GENE FUSION
NTRK 1/2/3 GENE FUSIONS

HEREDITARY PANELS*

☐ HEREDITARY CANCER DISORDERS
☐ HEREDITARY BRCA1, BRCA2
☐ HEREDITARY COLON CANCER PANEL
☐ HEREDITARY HBOUC PANEL
(BRCA1, BRCA2 INCLUDED)
☐ HEREDITARY LYNCH SYNDROME PANEL
☐ HEREDITARY PANCREATIC CANCER PANEL
☐ HEREDITARY PROSTATE CANCER PANEL

INDIVIDUAL TESTING

☐ NGS SOMATIC GENE PANEL
☐ PD-L1 EXPRESSION
☐ MSI
☐ ALK GENE FUSION
☐ ROS1 GENE FUSION
☐ NTRK 1/2/3 GENE FUSIONS

*See full list of all somatic and hereditary genes at www.circulogene.com/tests

AUTHORIZING SIGNATURE REQUIRED

This requisition constitutes a certification of medical necessity and intent to use the results of test(s) ordered. All of the information on this form is true and correct. We have obtained patient informed consent* and authorize CIRCULOGENE to release the results and patient information for reimbursement purposes. To the best of my knowledge, I certify that (if ordered) this patient qualifies for applicable hereditary testing.

*CIRCULOGENE can provide a Patient Genetic Testing Consent form and a Hereditary Cancer Screening Questionnaire if requested.

SIGNATURE _____ DATE _____

CIRCULOGENE

BILLING INFORMATION **INCLUDE COPY OF INSURANCE CARD & I.D.**

SPECIMEN ORIGIN (MUST CHOOSE 1):

☐ NON-HOSPITAL PATIENT ☐ HOSPITAL PATIENT (IN) ☐ HOSPITAL PATIENT (OUT)

PAYMENT OPTIONS:

BILL TO: ☐ INSURANCE ☐ PATIENT/SELF PAY ☐ BILL CHARGES TO OTHER HOSPITAL/FACILITY:

☐ MEDICARE ☐ MEDICAID ☐ CLIENT BILL

PRIOR AUTHORIZATION# (IF AVAIL):

PRIMARY INSURANCE

CARRIER

POLICY # GROUP #

SUBSCRIBER DOB

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD

SECONDARY INSURANCE

CARRIER

POLICY # GROUP #

SUBSCRIBER DOB

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD

CREDIT CARD NUMBER SEC. CODE

NAME ON CARD EXPIRATION DATE

SPECIMEN REQUIREMENTS AND PROCEDURES

- Use standard lavender sample tube provided
- Fill entire tube
- Gently invert tube 5 times
- Refrigerate immediately after inverting (do not freeze)
- Specimen viability is 7 days NOT including collection date (if kept refrigerated)
- Tube must include one label, patient name, date of birth, and phlebotomist signature
- Apply label correctly
- Follow packing instructions on shipper box when ready to ship. Keep refrigerated until ready to ship.