6575 Snowdrift Road, Suite 106, Allentown, PA 18106
Phone: (484) 244-2900 · Fax: (484) 244-2904 · **www.ctgt.net**
(CLIA# 39D1027912 · CAP# 7190738 · NPI# 1952866824)

TARGETED VARIANT TEST REQUISITION FORM

Please print clearly and provide all requested information. HNL Genomics (CTGT) cannot initiate testing unless this

PATIENT / SPECIMEN INFORMATION

PATIENT NAME – LAST, FIRST, MI	☐ M ☐ F	MRN	DATE OF BIRTH (MM-DD-YYYY)
ADDRESS		PHONE	ETHNICITY
CITY, STATE, ZIP		NAME OF LEGAL GUARDIAN IF PATIENT IS A MINOR	
TYPE OF SPECIMEN	DATE OF COLLECTION	DATE AND TIME OF RECEIPT (TO BE COMPLETED BY CTGT)	

REPORTING INFORMATION

REFERRAL SOURCE

REFERRED BY	NPI NUMBER	GENETIC COUNSELOR	
INSTITUTION		PHONE	FAX
ADDRESS		E-MAIL	
CITY, STATE, ZIP		**SIGNATURE (REQUIRED** – By signing, you agree to the Terms on page 10 of this form)	

ADDITIONAL REPORTS

REFERRING LAB	CONTACT PERSON	
ADDRESS	PHONE	FAX
CITY, STATE, ZIP	REFERRING LAB ID#	

PAYMENT INFORMATION

☐ INSTITUTIONAL BILLING

FACILITY NAME	CONTACT PERSON	
ADDRESS	PHONE	FAX
CITY, STATE, ZIP	E-MAIL	

☐ SELF PAY (ALSO REQUIRED FOR ALL INSURANCE CASES – PLEASE SEE "INSURANCE" BELOW.)

☐ CHECK ☐ M.O.	Please make check or money order payable to **Health Network Laboratories**.	CARD HOLDER NAME	BILLING ZIP CODE
☐ MC ☐ VISA	ACCOUNT NUMBER	EXPIRATION DATE	3 DIGIT SECURITY CODE (on back of card)
The total cost of testing is $_____. I agree that CTGT, LLC. shall bill this amount to my credit card.		**SIGNATURE OF CARDHOLDER (REQUIRED)**	

☐ **INSURANCE - Important note to Patients:** CTGT does not participate with any health plan, and CANNOT guarantee that your plan will reimburse you or CTGT for our testing services. By choosing Insurance Billing, **you agree that CTGT will charge the account listed in the Self Pay section above BEFORE testing will be initiated**. You may then seek reimbursement from your insurance company by selecting one of the following options:

☐ Send copy of invoice to Patient at the address provided in the Patient information section above. Patient will submit a claim to insurance company.

☐ Submit invoice to my insurance provider on my behalf. Any funds collected by HNL Genomics (CTGT) will be forwarded to the Patient at the address provided

In addition to completing the information below, be sure to provide a clear copy of both the front and back of your insurance card, and sign below.

NAME OF INSURED		RELATIONSHIP TO PATIENT
INSURANCE ID NUMBER		GROUP NUMBER
PRE-AUTHORIZATION NUMBER	DATE(S) AUTHORIZATION VALID	INSURANCE COMPANY PHONE NUMBER

SIGNATURE OF INSURED (REQUIRED)

PLEASE CONTACT OUR OFFICE PRIOR TO SENDING SPECIMEN IF THERE ARE ANY QUESTIONS.

Patient Name:	Patient DOB:

Prenatal testing: ☐ Yes ☐ No Anticipated delivery date: _____ ☐ Female ☐ Male

☐ 1389: Maternal cell contamination testing *(recommended for all prenatal testing)*

Has karyotyping been performed? ☐ Yes ☐ No _____

TARGETED VARIANT TESTING

Individual to be tested:

☐ Affected/Symptomatic ☐ Unaffected/Asymptomatic

Proband Name: _____

Proband DOB: _____

Proband Case #: _____

Relationship to Proband: _____

☐ 1387 One Mutation ☐ 2027 Three Mutations

☐ 1388 Two Mutations ☐ 2044 CNV Mutation Deletion/Duplication Analysis

Gene/Mutation: _____

FAMILY HISTORY

Is there a family history of disease for which the patient is being tested? ☐ Yes ☐ No

Relationship to the individual being tested	Maternal	Paternal	DX	Age at DX
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

MEDICAL RECORDS

Clinical history for this individual is required for variant reclassification. Please include relevant clinical notes and other medical records or provide a brief description of the individual's clinical features in this box. If the patient has no relevant clinical features, please indicate in this box.

OTHER NOTES

TERMS OF SERVICES

The contracted price for any tests on the requisition form applies to that test only. Included in the contract price is the service of answering any question regarding test results. Additional charges apply to parental or familial testing. Additional charges may apply to any future requests relating to this test.

HNL Genomics (CTGT) is not responsible for obtaining or submitting blood, tissue or other samples from patients for testing, nor is it responsible for communicating test results to patients. HNL Genomics (CTGT), therefore, assumes no liability for: Any injury or illness incurred from obtaining a blood sample, biopsy or other specimen. Mislabeling or misidentification of submitted samples. Incorrect or incomplete information provided in test requisition forms. Information provided to HNL Genomics (CTGT) outside of its requisition forms or order process. Any loss incurred as a result of communicating the outcome of any genetic tests to patients or their representatives. HNL Genomics (CTGT) further disclaims any liability for incorrect or incomplete information in any written or verbal communication other than test results reports prepared by HNL Genomics (CTGT), including, but not limited to, its web site, brochures, technical information, emails, letters or telephone conversations. IN NO EVENT SHALL CTGT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, CONSEQUENTIAL OR PUNITIVE DAMAGES ARISING OUT OF ANY USE OF OR INABLITY TO USE CTGT'S SERVICES, WHETHER BASED ON WARRANTY, CONTRACT, TORT OR ANY OTHER LEGAL THEORY, REGARDLESS OF WHETHER CTGT IS ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.