MicroGen Health
CLIA# 49D2178444
Laboratory Director: Dr. Shamaladevi Nagarajarao, Ph.D

MicroGen Health 14225 Sullyfield Circle, Suite E, Chantilly, Virginia 20151
PH: 571-775-1973 Fax: 571-775-2012, Email: orders@microgenhealth.com,
www.microgenhealth.com

# PULMONARY TEST REQUISITION FORM



**COMPLETE ENTIRE FORM AND SUBMIT CLINIC NOTES/PEDIGREE TO AVOID DELAYS**

## PATIENT INFORMATION

Name (Last First MI)

Date of Birth (MM/DD/YYYY) | Date of Death (if applicable)

Phone Number

Email

Address

City | State | Zip

Biological Sex ☐ F ☐ M

## FAMILY HISTORY*

☐ None (Maternal) ☐ Maternal hx unknown ☐ None (Paternal) ☐ Paternal hx

Relationship to patient..... ☐ Maternal ☐ Paternal
Diagnosis .....Dx age.....
Relationship to patient..... ☐ Maternal ☐ Paternal
Diagnosis .....Dx age.....

## SPECIMEN INFORMATION* (For Phlebptomy service, select all services you are requesting)

☐ Buccal Swab

| Collection Date | Specimen ID | Medical Record# |
|---|---|---|
| | | |

**Ethnicity:** ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Ashkenazi Jewish ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ Other

Phelebotomy Service Request: ☐ Philebotomy Draw ☐ Insurance preverification first ☐ Send kit to patient

*As the patient's clinician, I am unaware of any potential for complication or difficulty in drawing blood for the listed patient (s). I understand that phebotomist has full authority to refuse to draw any patient if the safety of the phelebotomist and / or patient (s) are in question.

## PATIENT HISTORY ☐ No personal history of pulmonology disease

PLEASE SUPPLY CLINIC NOTES AND PEDIGREE | If pregnant, due date: | Upcoming Procedure date:

## COMPREHENSIVE PULMONALOGY PANEL ☐ CHECK ALL

ABCA3, CCDC39, CCDC40, CFTR, CHAT, CHRNA1, CHRNB1, CHRND, CHRNE, COLQ. CSF2RA, CSF2RB, DKC1. DNAAF1, DNAAF2, DNAH1, DNAH11, DNAH5, DNAI1, DNAI2. DNAL1, EDN3, EFEMP2, ELMOD2, ELN. FBLN5, FLCN, FOXF1, GAS8, GLRA1, HPS1, HPS4, ITGA3, LTBP4, MECP2, NAF1, NF1, NKX2-1, NME8, PARN, PHOX2B, PIH1D3, RAPSN, RET, RSPH3, RSPH4A, RSPH9, RTEL1, SCN4A, SCNN1A, SCNN1B, SERPINA1, SFTPA1. SFTPA2, SFTPB, SFTPC, SLC34A2, SLC6A5, SLC7A7, SMPD1, STAT3, TERC, TERT, TINF2, TSC1, TSC2, ZEB2

## REASONS FOR TESTING

☐ Positive newborn screen
☐ Infections: .....
☐ Sweat chloride:.....mmol/L
☐ Sweat chloride: ☐ <40 ☐ 40-60 ☐ <60
☐ CBACD
☐ Meaconium ileus
☐ Pancreatic insufficiency IRT level:.....
☐ Respiratory distress, explain:.....
☐ Ultrasound findings:.....
☐ Pancreatic insufficiency IRT level:.....
☐ Respiratory distress, explain:.....
☐ Ultrasound findings:.....
☐ Other:.....

Relevant lab results (include copies if possible)

## ORDERING PHYSICIAN/SENDING FACILITY (Each Listed person will receive a copy of the report)

Facility Name (Facility Code): | Client: | Address:
Phone: | State/Country: | City: | Zip:

Ordering Licensed Provider Name (Last, First)(Code):
NPI# | Phone: | Fax/Email:

Genetic Counselor or Other Medical Provider Name (Last, First)(Code):
Phone: | Fax/Email:

## ICD-10 Codes

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

## ☐ INSURANCE BILLING (Include copy of both sides of insurance card)

Patient Relation to Policy Holder? ☐ Self ☐ Spouse ☐ Child

| Insurance Company | Policy # | HMO # |
|---|---|---|
| | | |

Out Of Pocket:
We will start testing immediately, unless you check the box below. We will attempt to contact you if estimated out-of- Pocket costs are > USD $100.
☐ Do not start testing until I approve payment terms regarding estimated out-of-pocket costs
Patient agrees to contact regarding out-of-pocket amount by:
☐ Email ☐ Phone (includes tests) - confirm mobile # .....

Special Billing Notes:

## ☐ INSTITUTIONAL BILLING ☐ SELF-PAY

Facility Name ☐ Send Invoice to facility Address above

Address

Contact Name

Phone Number

E-mail

Fax

☐ PATIENT PAYMENT ☐ Check (Payable To ) ☐ Credit Card

## INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)

Will patient management be changed depending on the test result?

☐ Yes ☐ No ☐ STAT TEST: Date result Needed (if Known) .....

## PATIENT HISTORY FOR PULMONARY TESTING

**Does the patient have symptoms?** (if yes, check all that apply) ☐ No ☐ Yes ☐ Unknown

☐ PAH
☐ Pulmonary capillary hemangiomatosis (PCH)
☐ Pulmonary veno-occlusive disease (PVOD)
☐ Shortness of breath
☐ Syncope

☐ Fatigue ☐ Chest pain
☐ Palpitation ☐ Edema
☐ Other:.....

**Does the patient have other risk factors for pulmonary hypertension?** ☐ No ☐ Yes (Check all that apply) ☐ Unknown

☐ Lung disease ☐ Heart disease ☐ Cirrhosis
☐ Pulmonary embolism ☐ Connective tissue disease ☐ HIV ☐ Other:.....

**Has the patient's mean pulmonary artery pressure been measured?** ☐ No ☐ Yes ☐ Unknown

If yes, what was result at rest?.....mmHg ☐ Normal ☐ Abnormal ☐ Unknown

What was result during exercise?.....mmHg ☐ Normal ☐ Abnormal ☐ Unknown

**Has the patient undergone previous DNA testing for this condition?** ☐ No ☐ Yes ☐ Unknown

If Yes, describe the test performed and result :.....

.....

**Is there any relevant family history?** ☐ No ☐ Yes ☐ Unkown

If Yes, attach a pedigree or specify the Relative's Relationship to the patient. List their symptoms and age of onset:.....

.....

## STOP PATIENT SIGNATURE

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to MicroGen Health its assigned affiliates and authorized representatives for laboratory services furnished to me by MicroGen Health. I irrevocably designate, authorize and appoint MicroGen Health or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, summary plan description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to MicroGen Health immediately upon receipt. I hereby authorize MicroGen Health its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to MicroGen Health, in compliance with federal and state laws. MicroGen Health, its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of MicroGen Health and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance.

**Signature of Patient or Patient Representative / Relationship to Patient** **Date:**

**Parent/Guardian signature** **Date:**

☐ **By Checking this box, the ordering provider certifies that the patient cannot physically Sign the Release and Consent**

## TO BE FILLED IN BY PHYSICIAN

## ICD-10 DIAGNOSIS CODES WITH DESCRIPTION

☐ C34.1 - Malignant Neoplasm of upper lobe, right bronchus or lung
☐ C34.12 - Malignant Neoplasm of upper lobe, left bronchus or lung
☐ C34.2 - Malignant Neoplasm of Middle lobe, bronchus or lung
☐ C34.31 - Malignant Neoplasm of lower lobe, right bronchus or lung
☐ C34.32 - Malignant Neoplasm of lower lobe, left bronchus or lung
☐ G47.33 - Obstructive sleep apnea
☐ I27.0 - Primary Pulmonary Hypertension
☐ J44.1 - Chronic Obstructive Pulmonary Disease with acute exacerbation
☐ J44.9 - Chronic Obstructive Pulmonary disease NOS
☐ J20.0 - Acute bronchitis due to Mycoplasma pneumoniae
☐ J20.1 - Acute bronchitis due to Hemophilus influenzae
☐ J20.3 - Acute bronchitis due to coxsackievirus
☐ J45.30 - Mild Persistent Asthma
☐ J45.32 - Mild Persistent Asthma with status asthmaticus
☐ J45.41 - Moderate persistent Asthma with acute exacerbation
☐ R91.8 - Nonspecific abnormal finding of lung field in diagnostic imaging
☐ R94.2 - Abnormal results of pulmonary function studies
☐ A41.9 - Sepsis, unspecified organism Malignant neoplasm of trachea, bronchus, lung
☐ C33 - Trachea

☐ J20.5 - Acute bronchitis due to respiratory syncytial virus
☐ J20.6 - Acute bronchitis due to rhinovirus
☐ J20.7 - Acute bronchitis due to echovirus
☐ J20.8 - Acute bronchitis due to other specified organisms
☐ J28.0 - Acute pulmonary Edema
☐ R06.02 - Shortness of Breath
☐ R06.2 - Sweezing | R05-Cough
☐ R07.1 - Chest pain on breathing
☐ R07.81 - Pleurodynia
☐ J45.31 - Mild Persistent Asthma with acute exacerbation
☐ J45.40 - Moderate persistent Asthma
☐ J45.42 - Moderate persistent Asthma with status asthmaticus
☐ J45.909 - Unspecified asthma, uncomplicated
☐ J44.9 - Chronic obstructive pulmonary disease, unspecified
☐ J90 - Pleural effusion, not elsewhere classified
☐ J98.11 - Atelectasis
☐ J98.19 - Other pulmonary collapse
☐ J98.2 - Interstitial emphysema
☐ J81.0 - Acute pulmonary edema

## ICD-10 DIAGNOSIS CODES WITH DESCRIPTION

- ☐ C34.30 - Lower lobe bronchus or lung
- ☐ C34.80 - Overlapping sites of unspecified bronchus or lung
- ☐ G47.33 - Obstructive sleep apnea (adult) (pediatric)
- ☐ I26.99 - Other pulmonary embolism without acute corpulmonale
- ☐ I95.9 - Hypotension, unspecified
- ☐ J20.1 - Acute bronchitis due to Hemophilius influenzae
- ☐ J20.2 - Acute bronchitis due to streptococcus
- ☐ J20.4 - Acute bronchitis due to parainfluenza virus
- ☐ J20.9 - Acute bronchitis, unspecified
- ☐ J16.8 - Pneumonia due to other specified infectious organisms
- ☐ J18.9 - Pneumonia, unspecified organism
- ☐ J40 - Bronchitis, not specified as acute or chronic
- ☐ J45.20 - Mild Intermittent Asthma
- ☐ J45.23 - Mild Intermittent Asthma with status asthmaticus
- ☐ J45.21 - Mild Intermittent Asthma with acute exacerbation
- ☐ J45.52 - Severe persistent Asthma with status asthmaticus
- ☐ J45.50 - Severe persistent Asthma
- ☐ J45.51 - Severe persistent Asthma with acute exacerbation
- ☐ C34.00 - Unspecified main bronchus
- ☐ C34.10 - Upper lobe unspecified bronchus or lung
- ☐ J96.0 - Acute respiratory failure
- ☐ J96.02 - Acute respiratory failure with hypercapnia
- ☐ J96.10 - Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
- ☐ J96.11 - Chronic respiratory failure with hypoxia
- ☐ J96.12 - Chronic respiratory failure with hypercapnia
- ☐ J96.20 - Acute/Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
- ☐ J96.21 - Acute/Chronic respiratory failure with hypoxia
- ☐ J96.22 - Acute/Chronic respiratory failure with hypercapnia
- ☐ N17.9 - Acute kidney failure, unspecified
- ☐ R09.89 - Other specified symptoms and signs involving the circulatory and respiratory systems
- ☐ R05 - Cough
- ☐ R22.2 - Localized swelling, mass and lump, trunk (chest mass) (localized swelling of chest)
- ☐ R91.1 - Solitary pulmonary nodule
- ☐ R09.02 - Hypoxemia
- ☐ J98.4 - Other disorders of lung
- ☐ R65.20 - Severe sepsis without septic shock (sequence theunderlying infection first
- ☐ Z85.118 - Personal history of malignant neoplasm of bronchus and lung
- ☐ Z79.01 - Long-term (current) use of anticoagulants
- ☐ J95.84 - Transfusion related acute lung injury (TRALI)
- ☐ J96.00 - Acute respiratory failure, unspecified whether with hypoxia or hypercapnia

STOP **ORDERING PHYSICIAN SIGN HERE** Physician must only order tests that are medically necessary for the diagnosis or treatment of a patient

**CONFIRMATION OF INFORMED CONSENT, PRE-TEST GENETIC COUNSELING, AND MEDICAL NECESSITY FOR GENETIC TESTING**

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent. I Confirm that testing is medically necessary and the test results may impact medical management for the patient. Furthermore, all information on this Requisition Form is true to the best of my knowledge. My signature applies to the attachment letter of medical necessity. (unless this box is checked ☐ )

**Signature Required for processing Medical Professional Signature:** **Date :**

**Ordering Physician Signature** **Date:**