



Montana's Medical Genetics Program

2755 Colonial Drive, PO Box 5539, Helena, MT 59604
(406) 444-7500 1-800-447-6614 FAX (406) 444-1022

Drug Metabolizing Enzymes Test Request Form (Cytochrome P450)

Please send this completed form with the specimen.

PATIENT INFORMATION:

Patient's Last Name _____

First Name _____ Sex Male Female Unk

Birth Date _____

Social Security # (required) _____

Date Collected _____ Date Received _____

Responsible Party (Relation to Pt): _____

Address _____

Home Phone _____ Work Phone _____

Ethnic Background (Check all that apply) European Caucasian Hispanic
 Native American African American Asian Other

TEST REQUESTED: Please check all that apply. (Test descriptions with CP codes and prices faxed on request)

- Drug Metabolizing Enzyme Panel (CYP2D6, CYP2C9, CYP2C19)
- CYP2D6 CYP2C9 CYP2C19

If test results are ABNORMAL, contact ordering physician about Pharmacogenetic Consultation services.

SPECIMEN TYPE: Blood - One (1) EDTA (purple top tube) 5-10 ml, min.,
1 ml for infant, room temperature **Please notify the laboratory when a specimen is being sent.** 1-800-447-6614 ext. 7532

STAT (Additional charges apply)

DIAGNOSIS: _____

REASON FOR TESTING: Limited response/no therapeutic benefit
 ADR/drug sensitivity/toxicity Other

STATEMENT OF CONSENT AND RELEASE: (Sample will not be processed until consent is obtained)

I hereby certify that the information provided is true and accurate. I consent to the collection of specimens for the purpose of DNA testing. I understand and agree that Shodair Children's Hospital's Medical Genetics Laboratory reserves the right to request recollection of samples for retesting and to store samples for future additional tests, if necessary.

I understand that while DNA testing is highly accurate and widely accepted, as in all testing there is a possibility of delay or error. I understand that samples and the DNA they contain become the exclusive property of Shodair Children's Hospital. I also understand that prescription drug dosages and schedules should never be altered without consulting a physician.

Shodair Children's Hospital will not release personal, identifiable information of any kind to a third party without my express written instructions. I also understand and agree that Shodair Children's Hospital reserves the right to provide de-identified information of a statistical nature to accrediting agencies and reserves the right to use any such anonymous information for research purposes.

PATIENT SIGNATURE (If minor/or unable to consent, signature of legal guardian or conservator)

DATE

PHONE CONSENT obtained from legal guardian or conservator)

DATE

Physician or RN witness to phone consent

DATE

Shodair Lab #:

Ref Lab #:

REFERRAL (Check which apply)

- PHYSICIAN/ HEALTH PROFESSIONAL
- INSTITUTION/ CLINIC/ LAB

Name

Address

City/State/Zip

Phone

FAX

Duplicate Reports to:

Name

Address

City/State/Zip

Phone

FAX

BILLING INFO: (Check which apply)

- REFERRING INSTITUTION/CLINIC/OFFICE

Institution Name

Inpatient: (circle) Yes No

Billing Address

City/State/Zip

Financial Contact

Phone

INSURANCE

- **Commercial:** Provide front/back copy of card
- **Managed Care (HMO):** Copy of card with authorization
- **Medicaid (MT, WY, CO, UT, CA, ID):** Copy of card

Name of Policy Holder

Insurance Co. / Policy #

Social Security # (Guarantor)

Medicaid # / State

- SELF-PAY (Please call the Lab to arrange)