TEST REQUISITION FORM

PGx Panels

PATIENT

LAST NAME	FIRST
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ◯ Male ◯ Female ◯ Unknown
MED REC#/PATIENT IDENTIFIER	
ADDRESS	
CITY / STATE/PROVINCE / POSTAL / COUNTRY	
PHONE	EMAIL

ORDERING PROVIDER

INSTITUTION/PRACTICE	INSTITUTION
PROVIDER LAST NAME	PROVIDER FIRST
NPI (USA)/MINC	PROVIDER TITLE (MD, DO,
PROVIDER ADDRESS	
CITY / STATE/PROVINCE / POSTAL CODE / COUNTRY	
PROVIDER	FAX REPORT TO

I have read the Informed Consent document and I give permission to Elina Labs to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Elina Labs and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications

☐ Opt out of research

☐ Check this box if you are a New York state resident and give permission for Elina Labs to retain any remaining sample longer than 60 days after the completion of testing.

I attest that the patient has received and read the Elina Labs Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Elina Labs Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

X _____ _____

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES) **DATE (MM/DD/YYYY)**

X _____ _____

ORDERING PROVIDER SIGNATURE (REQUIRED) **DATE (MM/DD/YYYY)**

SPECIMEN INFORMATION

Sample Type

◯ Blood ◯ Buccal ◯ Extracted DNA & DNA Source: _____
(Blood, Buccal, Tissue, Fibroblast)

Sample Draw Date: _____
(MM/DD/YYYY)

Shipping Instructions

Label each specimen tube with the patient's full name, date of birth, and collection date.

Send completed TRF with collected sample to:
5380 P'tree Ind. Blvd., Suite 200
Norcross, GA 30071

- ☐ **FT-TP01241** PGx Comprehensive Panel 44 genes
- ☐ **FT-TP01260** PGx Focus Panel 18 genes
- ☐ **FT-TP01290** PGx Cardio Panel 8 genes
- ☐ **FT-TP01291** PGx Orthopedic Panel 7 genes
- ☐ **FT-TP01292** PGx Pain Management Panel 5 genes
- ☐ **FT-TP01293** PGx Mental Health Panel 4 genes
- ☐ **FT-TP01294** PGx Urology Panel 4 genes

PGx Requisition Genes

5380 P'tree Ind. Blvd., Suite 200
Norcross, GA 30071
T: (770) 807-0466 F: (470) 545-0405
Lab Director: Thomas L. O'Rourke, MD
CLIA #: 11D2212215
support@elinalabs.com

FT-TP01241 PGx Comprehensive Panel

44 genes
ABCB1, ACE, ANKK1, APOE, ATM, BCHE, CES1, COMT, CYP2B6, CYP2C19, CYP2C8, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, DPYD, DRD2, ERCC1, F2, F5, G6PD, GGCX, GRIK4, GSTP1, HLA-B, HTR1A, HTR2A, HTR2C, IFNL4, ITPA, KIF6, MTHFR, NAT2, NQO1, NUDT15, OPRM1, RYR1, SLCO1B1, TPMT, UGT1A1, UGT1A4, VKORC1, XRCC1

FT-TP01260 PGx Focus Panel

18 genes
BCHE, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A5, CYP4F2, DPYD, G6PD, HLA- B, IFNL4, NAT2, NUDT15, RYR1, SLCO1B1, TPMT, UGT1A1, VKORC1

FT-TP01290 PGx Cardio Panel

8 genes
CYP2C19, CYP2D6, CYP3A4, CYP3A5, F2, F5, MTHFR, VKORC1

FT-TP01291 PGx Orthopedic Panel

7 genes
CYP2D6, CYP3A4, CYP3A5, F2, F5, MTHFR, VKORC1

FT-TP01292 PGx Pain Management Panel

5 genes
COMT, CYP2C19, CYP2D6, CYP3A4, CYP3A5

FT-TP01293 PGx Mental Health Panel

4 genes
CYP2C19, CYP2D6, CYP3A4, CYP3A5

FT-TP01294 PGx Urology Panel

4 genes
CYP2C19, CYP2C9, CYP2D6, CYP3A4