

CARDIOPULMONARY NGS PANEL

Test Requisition

Patient Information (required)

| | | | | | |
|--|---|--|---|---|--------------------------------|
| Patient Name (Last, First) | Date of Birth (mm/dd/yyyy) | Age | Gender | <input type="checkbox"/> Male <input type="checkbox"/> Female | Phone |
| Street Address | City, State, Zip | | Email | | |
| Patient Ethnicity (Select all that apply) | <input type="checkbox"/> African American <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Caucasian <input type="checkbox"/> East Indian | <input type="checkbox"/> French Canadian <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Other |
| Payment Options | <input type="checkbox"/> Commercial Insurance: Please attach a copy of front and back of insurance card <input type="checkbox"/> Self-Pay: OmniHealth DX will contact patient to obtain payment <input type="checkbox"/> Invoice Practice/Institutional Bill/Facility Bill | | <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid | | |

Ordering Physician and/or Other Licensed Medical Professional Information (required)

| | | |
|----------------|-----------------------------------|---------------------|
| NPI # | Name (Last, First) | Medical Credentials |
| Street Address | City, State, Zip | |
| Facility Name | Direct Office Contract (required) | Phone |

Clinical Notes

Patient Informed Consent (Please sign)

I confirm that I have been informed about the details of Cardiopulmonary NGS Panel ordered for me by my provider. I understand the risks, benefits and limitations of testing and I voluntarily consent to testing. I give permission to OmniHealth DX to perform the genetic tests described. I understand I am financially responsible for services performed. I authorize OmniHealth DX to submit claims to my medical insurance on my behalf, to give my health plan, my health information on this form and other information provided by my healthcare provider that is necessary for reimbursement.

Patient Signature

Date

Confirmation of Informed Consent and Medical Necessity

The tests ordered are medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine the patient's medical management and treatment decision. The person listed as the Ordering Physician is legally authorized to order the test(s) requested herein. The patient was provided with information about genetic testing and has consented to have genetic testing performed.

Ordering Physician Signature

Date

Specimen Information (Required)

| | | | |
|--------------------|--|--------------|--------------------------|
| Date of Collection | Specimen Type <input type="checkbox"/> Oral Buccal/Cheek Swab <input type="checkbox"/> Saliva <input type="checkbox"/> Peripheral blood | Collected By | ICD-10 Diagnosis Code(s) |
|--------------------|--|--------------|--------------------------|

Test Order Information

CARDIOPULMONARY NGS PANEL (236 GENES)

ABCC9 ACTA2 ACTC1 ACTN2 ACVRL1 ADAMTS2 AKAP9 ALDH18A1ALMS1 ALPK3 ANK2 ANKRD1 APOB ATP6V0A2 ATP6V1E1 ATP7A B3GALT6 B3GAT3 B4GALT7 BAG3 BGN BMPR2 BRAF CACNA1C CACNA2D1CACNB2 CALM1 CALM2 CALM3 CASQ2 CAV1 CAV3 CAVIN4 CBS CCDC39 CCDC40 CFTR CHAT CHRM2 CHRNA1 CHRNA1B CHRNA1C CHRNA1D CHRNA1E CHRNA1F CHRNA1G CHRNA1H CHRNA1I CHRNA1J CHRNA1K CHRNA1L CHRNA1M CHRNA1N CHRNA1O CHRNA1P CHRNA1Q CHRNA1R CHRNA1S CHRNA1T CHRNA1U CHRNA1V CHRNA1W CHRNA1X CHRNA1Y CHRNA1Z CHRNA1AA CHRNA1AB CHRNA1AC CHRNA1AD CHRNA1AE CHRNA1AF CHRNA1AG CHRNA1AH CHRNA1AI CHRNA1AJ CHRNA1AK CHRNA1AL CHRNA1AM CHRNA1AN CHRNA1AO CHRNA1AP CHRNA1AQ CHRNA1AR CHRNA1AS CHRNA1AT CHRNA1AU CHRNA1AV CHRNA1AW CHRNA1AX CHRNA1AY CHRNA1AZ CHRNA1BA CHRNA1BB CHRNA1BC CHRNA1BD CHRNA1BE CHRNA1BF CHRNA1BG CHRNA1BH CHRNA1BI CHRNA1BJ CHRNA1BK CHRNA1BL CHRNA1BM CHRNA1BN CHRNA1BO CHRNA1BP CHRNA1BQ CHRNA1BR CHRNA1BS CHRNA1BT CHRNA1BU CHRNA1BV CHRNA1BW CHRNA1BX CHRNA1BY CHRNA1BZ CHRNA1CA CHRNA1CB CHRNA1CC CHRNA1CD CHRNA1CE CHRNA1CF CHRNA1CG CHRNA1CH 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ICD Codes

| CODE | DESCRIPTION | CODE | DESCRIPTION | CODE | DESCRIPTION |
|-------|--|---------|--|--------|---|
| I10 | Essential (primary) hypertension | I49.9 | Cardiac arrhythmia, unspecified | J12.1 | Respiratory syncytial virus pneumonia |
| I11.9 | Hypertensive heart disease without heart failure | I50.9 | Heart failure, unspecified | J12.89 | Other viral pneumonia |
| I20.0 | Unstable angina | I50.89 | Other heart failure | J12.9 | Viral pneumonia, unspecified |
| I11.0 | Hypertensive heart disease with heart failure | I95.89 | Other hypotension | J22 | Unspecified acute lower respiratory infection |
| I24.9 | Acute ischemic heart disease, unspecified | J01.180 | Other acute sinusitis | | |
| I25.2 | Old myocardial infarction | J06.9 | Acute upper respiratory infection, unspecified | | |