OmniHealth Diagnostics
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CLIA# 45D2089485 | Lab Director: David Mehr, MD
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PRIMARY IMMUNODEFICIENCY NGS PANEL
Test Requisition

Patient Information (required)

Patient Name (Last, First)	Date of Birth (mm/dd/yyyy) Age	Gender ☐ Male ☐ Female	Phone
Street Address	City, State, Zip	Email	

Patient Ethnicity (Select all that apply)
☐ African American ☐ Caucasian ☐ French Canadian ☐ Mediterranean ☐ Other
☐ Ashkenazi Jewish ☐ East Indian ☐ Hispanic ☐ Middle Eastern

Payment Options
☐ **Commercial Insurance:** Please attach a copy of front and back of insurance card ☐ **Medicare** ☐ **Medicaid**
☐ **Self-Pay:** OmniHealth DX will contact patient to obtain payment
☐ **Invoice Practice/Institutional Bill/Facility Bill**

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 Primary Immunodeficiency 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 ☐ Oral Buccal/Cheek Swab ☐ Saliva ☐ Peripheral blood	Collected By	ICD-10 Diagnosis Code(s)

Test Order Information

PRIMARY IMMUNODEFICIENCY NGS PANEL (50 GENES)

ADA, ADAR, ATM, BLM, BRCA2, BTK, CFTR, CYBA, CYBB, F13B, F5, F7, F9, FANCC, FGB, G6PC1, G6PD, IFNGR1, IFNGR2, ITGB2, JAGN1, JAK2, MEFV, MPL, MSH6, MYD88, NCF1, NFKB2, NLRP1, NLRP12, NOD2, NRAS, PALB2, PIK3CD, PLCG2, PMS2, PTEN, PTPRC, RAG1, RAG2, RFXANK, RUNX1, SPINK5, STAT1, STAT3, STK4, TERT, TNFRSF13B, UNC13D, VPS13B

ICD Codes

CODE	DESCRIPTION
K11.9	Disease of salivary gland, unspecified
K12.2	Cellulitis and abscess of mouth
K13.70	Unspecified lesions of oral mucosa

CODE	DESCRIPTION
K11.9	Disease of salivary gland, unspecified
K38.8	Other specified diseases of appendix
K38.9	Disease of appendix, unspecified