

# PRIMARY IMMUNODEFICIENCY 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"/> <b>Commercial Insurance:</b> Please attach a copy of front and back of insurance card		<input type="checkbox"/> <b>Medicare</b>	<input type="checkbox"/> <b>Medicaid</b>	
<input type="checkbox"/> <b>Self-Pay:</b> OmniHealth DX will contact patient to obtain payment <input type="checkbox"/> <b>Invoice Practice/Institutional Bill/Facility Bill</b>					

### 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 <input type="checkbox"/> Oral Buccal/Cheek Swab <input type="checkbox"/> Saliva <input type="checkbox"/> Peripheral blood	Collected By	ICD-10 Diagnosis Code(s)
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### 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