OmniHealth Diagnostics
1840 N Greenville Ave Ste 176, Richardson, TX 75081
Phone 972-887-3444 | Fax 972-887-3443
CLIA# 45D2089485 | Lab Director: Akhtar Afshan Ali
www.OmniHealthDX.com

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

Test Order Information

EYE NGS PANEL (79 GENES)

ADGRV1 ALDH7A1 BEST1 BFSP1 BFSP2 CACNA1A CAV1 CAV2 CDH23 CDKL5 CFH CHD2 CLRN1 CNGA1 CRYAA CRYAB CRYGC CTSD CYP1B1 EYS FOXC1 FOXE3 FTL GABRG2 GALK1 GJB2 GJB6 GRIN2A HSF4 KCNQ2 LTBP2 MECP2 MYO15A MYO7A NR2E3 NRL OPN1LW OPN1MW OTOF PAX2 PAX6 PCDH15 PCDH19 PDE6A PDE6B PITX2 POLG PRPF31 PRRT2 RDH12 RHO RP1 RP2 RPE65 RPGR SCN1A SCN1B SCN2A SCN8A SIX1 SIX6 SLC26A4 SLC2A1 SLC9A6 STXBP1 SYNGAP1 TCF4 TGFBI TMC1 TMCO1 TMPRSS3 TPP1 TSC1 TSC2 USH1C USH1G USH2A WFS1 ZEB2