DIACARTA

CAP ACCREDITED

CLIA ID#: 05D2110800
Doc Number: Lab 108

VEXAS UBA1 Mutation Test Requisition Form

PART 1. PATIENT INFORMATION (REQUIRED)

Last Name | First Name | Middle Initial | Date of Birth (MM/DD/YYYY)

Street Address | City | State | Zip Code

Preferred Contact Phone #

☐ Home ☐ Mobile ☐ Work

Email

Gender
☐ Male ☐ Female ☐ Other

Geoancestry/Ethnicity
☐ African American ☐ White ☐ American Indian or Alaska Native ☐ Asian or Other Pacific Islander ☐ Hispanic or Latino ☐ Other/Unknown

PART 2. SAMPLE COLLECTION TYPE (REQUIRED)

☐ Blood ☐ Bone Marrow

Collection Date & Time

Sample Collected By

PART 3. PRACTICE/CLINIC INFORMATION (REQUIRED)

Clinic Name or Account Number

Physician Name

Medical Professional Consent
My signature constitutes a Certification of Medical Necessity, and I hereby authorize and order DiaCarta, Inc. to perform testing for this patient as indicated on this requisition, I have reviewed the medical consent on this form and will provide test interpretation to the patient as appropriate.

Signature and Date

PART 4. ICD-10 CODES (MOST COMMONLY USED ICD-10 CODES) (REQUIRED)

☐ M04.9 Autoinflammatory syndrome, unspecified
☐ D53.1 Macrocytic anemia
☐ D72.819 Leukopenia
☐ M35.81 Multisystem inflammatory syndrome
☐ D69.6 Thrombocytopenia, unspecified
☐ D46.9 Myelodysplastic syndrome, unspecified
☐ L30.9 Dermatitis, unspecified
☐ Other_____

PART 5. PATIENT INSURANCE INFORMATION (REQUIRED)

Where applicable please include a photocopy of insurance card(s) (both sides)

Please Select a Billing Option & Complete the Information below

☐ Insurance ☐ Cash Pay ☐ Credit Card ☐ Check ☐ Client Bill

Primary Insurance Carrier | Primary Insurance ID No. | Primary Insurance Group No.

PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Carrier | Secondary Insurance ID No. | Secondary Insurance Group No.

PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Dependent ☐ Other

PART 6. PATIENT CONSENT (REQUIRED)

I _____ (Patient or legal guardian name), request and authorize the DiaCarta Clinical Laboratory to perform the requested test(s) for the person(s) listed above. I acknowledge the benefits, risks, and limitations outlined below. I understand that my specimen(s) will be submitted to DiaCarta for the purpose of lab testing. I authorize DiaCarta to store my specimen in case additional testing is necessary. The DiaCarta Clinical Laboratory does not return patient samples. I can request additional tests or send out samples to other institutions if there is enough sample. Once my test result has been released, remaining samples may be de-identified to be used for laboratory quality control or research. I can withdraw my consent at any time by calling the DiaCarta laboratory at (800) 246-8878. My signature below indicates that I have read the above information. All my questions have been answered and my inquiries regarding the purpose of this test have been discussed and fully understood by me. DiaCarta will not balance bill the patient if insurance does not cover for the billed

AFFIX SPECIMEN BARCODE HERE

Patient Name (Print)

Patient Signature

Date