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www.cmmdx.org

LABORATORY REQUISITION

DATE ORDERED		DATE COLLECTED	TIME COLLECTED	COLLECTOR'S INITIALS
NAME: LAST, FIRST MIDDLE INT.				
ADDRESS			PHONE	
CITY, STATE ZIP				
SEX	MARITAL STATUS	BIRTH DATE	SOCIAL SECURITY NO.	
DIAGNOSIS/ICD-9 CODES PREFERRED				
Ordering Comment: _____		1 st _____		
Additional report to: _____		2 nd _____		
Physician _____ Fax _____		Note: Must include signs and symptoms to support medical necessity		

CLINICAL INFORMATION	
<p>For Cytochrome P450: Ethnicity: _____</p> <p>Relevant Clinical history, <i>e.g.</i>, depression, breast cancer, etc. Also include relevant Medical history pertinent to Pharmacy consult. (Attach if necessary)</p> <p>_____</p> <p>_____</p> <p>Relevant Drug(s) being considered: _____</p> <p>_____</p> <p>Relevant Drug(s) currently prescribed: _____</p> <p>_____</p> <p>OTC and Herbal medications (Frequency and dose) _____</p> <p>_____</p>	<p>Results of most recent renal function test (Creatinine clearance or serum Creatinine) for Pharmacy consult.</p> <p>_____</p> <p>_____</p> <hr/> <p>BILLING REQUIREMENTS</p> <p><input type="checkbox"/> Bill patient's insurance (Attach copy of insurance card) Professional component will be billed to patient's insurance. Attach copy of patient's insurance information and billing demographics.</p> <p><input type="checkbox"/> Bill other: (attach alternate arrangements) Include completed ABN; available at www.cmmdx.org Comment: _____</p> <p>_____</p>

Clinical Tests:
<input type="checkbox"/> Cytochrome P450 (specimen requirements: 3 mL whole blood in EDTA only, Do not freeze)

Research:
<input type="checkbox"/> DNA Banking
<input type="checkbox"/> Research study (Informed consent form must accompany all research study requests)

Comments _____