Macrogen Clinical Laboratory
1330 Piccard Drive
Suite 103
Rockville, MD 20850
Tel: (301) 251.1007
Fax: (301) 251.4006
Email: mclclia@macrogenusa.com

CLINICAL SEQUENCING REQUISITION FORM

PATIENT INFORMATION

First Name:	Last Name:		Middle (Initial):
Street Address:		DOB (MM/DD/YYYY):	Sex: ☐ M ☐ F
City:	State:	Tel.:	
		Fax:	
Zip Code:	Email:		
	Ethnicity:		

GENETIC TEST REQUESTED

Whole Exome Sequencing	Whole Genome Sequencing	Sanger Sequencing
☐ Single (Proband) (81415) ☐ Trio (Parents/Siblings) (81416)	☐ Single (Proband) (81425) ☐ Trio (Parents/Siblings) (81426)	☐ New ☐ Re-evaluation of WES (81417) ☐ Re-evaluation of WGS (81427)

Other (Specify):

SPECIMEN INFORMATION

Collection Date:	Specimen Type: ☐ Saliva ☐ Blood ☐ DNA

ORDERING PHYSICIAN (REQUIRED)

First Name:	Last Name:		Middle (Initial):
Street Address:		Title (MD, DO, MD/PhD):	
City:	State:	Tel.:	
		Fax:	
Zip Code:	Email:		

ADDITIONAL REPORT RECIPIENTS

Name:	Tel/Fax/Email:
Name:	Tel/Fax/Email:
Authorized Physician Signature:	

CLINICAL INFORMATION

(Test/Medical History, Current symptoms, Family history, etc.)

1. 4.

2. 5.

3. 6.

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BILLING INFORMATION

Patient Payment: ☐ Check (Payable to Macrogen Corp.) ☐ VISA ☐ MasterCard ☐ Amex ☐ Discover		Institute Payment: Institute Name:		
Card #:		Address:		
Expire Date:	CCV:	City:	State:	Zip:
Cardholder Name:		PO#:		
Amount:		Tel:	Email:	

Payment is due upon receipt of the service order by Macrogen Corp. Any payment not received by Macrogen Corp. within ten (10) business days after billing shall incur a late charge of five percent (5%). Once Macrogen Corp. takes initial test procedures, there shall be no reduction of fees or refund.

I agree that I am financially responsible for the full amount of the test price.

Name (Print): Date:

Signature:

STATEMENT OF MEDICAL NECESSITY

This test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the tests(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Medical Professional Signature (required):	Date: