

Pharmacogenomics Requisition



Qitek Labs of Oklahoma, LLC
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1. Account Information

Clinic Name: _____ Requesting Physician: _____
Address: _____ NPI #: _____
Clinic Phone: _____

2. Patient Information

REQUIRED: ENCLOSE A COPY OF THE FRONT AND BACK OF PATIENT'S INSURANCE CARD

Last: _____ First: _____ Middle Initial: _____
Address (Street, City, State, Zip): _____
Gender: M F Phone: _____ Date of Birth: _____ Email: _____
Social Security #: _____ Insurance Type: Commercial Medicare Medicaid Self Pay

I understand that I am responsible for all deductibles and co-pays for amounts not covered by insurance. By signing below, I acknowledge, authorize, and assign to Qitek Labs, LLC, any payment(s) made on my behalf for services provided to me by Qitek Labs, LLC. I also allow the release of any medical information necessary to process this claim.

Patient Signature: _____ Date: _____

3. ICD-10 Diagnosis Code(s)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> F33.9 Major depressive disorder, recurrent, unsp | <input type="checkbox"/> F25.9 Schizoaffective disorder, unspecified | <input type="checkbox"/> Z79.02 Long term (current) use of antithrombotics/antiplatelets | <input type="checkbox"/> E78.49 Other hyperlipidemia |
| <input type="checkbox"/> F32.9 Major depressive disorder, single episode, unsoec | <input type="checkbox"/> F41.1 Generalized anxiety disorder | <input type="checkbox"/> Z86.39 Personal history of other endocrine, nutritional and metabolic disease | <input type="checkbox"/> _____ |
| <input type="checkbox"/> F43.12 Post-traumatic stress disorder, chronic | <input type="checkbox"/> I10 Essential (primary) hypertension | <input type="checkbox"/> E78.01 Familial hypercholesterolemia | <input type="checkbox"/> _____ |
| <input type="checkbox"/> F11.23 Opioid dependence with withdrawal | <input type="checkbox"/> G89.29 Other chronic pain | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> F31.9 Bipolar disorder, unspecified | <input type="checkbox"/> Z79.01 Long term (current) use of anticoagulants | | <input type="checkbox"/> _____ |

4. Test(s) Requested

- Comprehensive Pain Management
 Cardiology Psychiatry

5. Collection Information

Sample Type: Buccal Swab
Time Collected: _____ AM / PM
Date Collected: _____ Collected by: _____

6. Current Medications

- | | | | | | | | |
|---|---|---------------------------------------|--|--|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> 5-fluorouracil | <input type="checkbox"/> Celexa | <input type="checkbox"/> Donepezil | <input type="checkbox"/> Haldol | <input type="checkbox"/> Mexitil | <input type="checkbox"/> Phenytoin | <input type="checkbox"/> Serax | <input type="checkbox"/> Trilafon |
| <input type="checkbox"/> Abilify | <input type="checkbox"/> Citalopram | <input type="checkbox"/> Doxepin | <input type="checkbox"/> Haloperidol | <input type="checkbox"/> Micronase | <input type="checkbox"/> Pimozide | <input type="checkbox"/> Sertraline | <input type="checkbox"/> Trimipramine |
| <input type="checkbox"/> Aciphex | <input type="checkbox"/> Clobazam | <input type="checkbox"/> Duloxetine | <input type="checkbox"/> Hydrocodone | <input type="checkbox"/> Mirtazapine | <input type="checkbox"/> Piroxicam | <input type="checkbox"/> Silenor | <input type="checkbox"/> Uftoral |
| <input type="checkbox"/> Actiq | <input type="checkbox"/> Clomipramine | <input type="checkbox"/> Effexor | <input type="checkbox"/> Iloperidone | <input type="checkbox"/> Morphine | <input type="checkbox"/> Pitavastatin | <input type="checkbox"/> Simvastatin | <input type="checkbox"/> Ultram |
| <input type="checkbox"/> Adderall | <input type="checkbox"/> Clopidogrel | <input type="checkbox"/> Effient | <input type="checkbox"/> Imipramine | <input type="checkbox"/> MS Contin | <input type="checkbox"/> Plavix | <input type="checkbox"/> Soma | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Amaryl | <input type="checkbox"/> Clozapine | <input type="checkbox"/> Efudex | <input type="checkbox"/> Imuran | <input type="checkbox"/> Naltrexone | <input type="checkbox"/> Prasugrel | <input type="checkbox"/> Stratterra | <input type="checkbox"/> Venlafaxine |
| <input type="checkbox"/> Amitriptyline | <input type="checkbox"/> Clozaril | <input type="checkbox"/> Elavil | <input type="checkbox"/> Inderal | <input type="checkbox"/> Nebivolol | <input type="checkbox"/> Pravachol | <input type="checkbox"/> Surmontil | <input type="checkbox"/> Vfend |
| <input type="checkbox"/> Amphetamine | <input type="checkbox"/> Codeine | <input type="checkbox"/> Enblex | <input type="checkbox"/> Invega | <input type="checkbox"/> Nexium | <input type="checkbox"/> Pravastatin | <input type="checkbox"/> Tabloid | <input type="checkbox"/> Vicodin |
| <input type="checkbox"/> Anaftranil | <input type="checkbox"/> Coreg | <input type="checkbox"/> Escitalopram | <input type="checkbox"/> Irbesartan | <input type="checkbox"/> Norpramin | <input type="checkbox"/> Prevacid | <input type="checkbox"/> Tacrolimus | <input type="checkbox"/> Vivitrol |
| <input type="checkbox"/> Ansaïd | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Esomeprazole | <input type="checkbox"/> Lansoprazole | <input type="checkbox"/> Nortriptyline | <input type="checkbox"/> Prilosec | <input type="checkbox"/> Tambocor | <input type="checkbox"/> Voriconazole |
| <input type="checkbox"/> Aricept | <input type="checkbox"/> Crestor | <input type="checkbox"/> Fanapt | <input type="checkbox"/> Lescol | <input type="checkbox"/> Olanzapine | <input type="checkbox"/> Pristiq | <input type="checkbox"/> Tamsulosin | <input type="checkbox"/> Vyvanse |
| <input type="checkbox"/> Aripiprazole | <input type="checkbox"/> Cymbalta | <input type="checkbox"/> Feldene | <input type="checkbox"/> Lexapro | <input type="checkbox"/> Omeprazole | <input type="checkbox"/> Prograf | <input type="checkbox"/> Tegafar | <input type="checkbox"/> Warfarin |
| <input type="checkbox"/> Atomoxetine | <input type="checkbox"/> Darifenacin | <input type="checkbox"/> Fentanyl | <input type="checkbox"/> Lipitor | <input type="checkbox"/> Ondansetron | <input type="checkbox"/> Propafenone | <input type="checkbox"/> Tetrabenazine | <input type="checkbox"/> Wellbutrin |
| <input type="checkbox"/> Atorvastatin | <input type="checkbox"/> Desipramine | <input type="checkbox"/> Fesoterodine | <input type="checkbox"/> Lisdexamphetamine | <input type="checkbox"/> Onfi | <input type="checkbox"/> Propranolol | <input type="checkbox"/> Thioguanine | <input type="checkbox"/> Xeloda |
| <input type="checkbox"/> Avapro | <input type="checkbox"/> Desvenlafaxine | <input type="checkbox"/> Flecainide | <input type="checkbox"/> Livalo | <input type="checkbox"/> Orap | <input type="checkbox"/> Protonix | <input type="checkbox"/> Thioridazine | <input type="checkbox"/> Xenazine |
| <input type="checkbox"/> Azathioprine | <input type="checkbox"/> Detrol | <input type="checkbox"/> Flomax | <input type="checkbox"/> Lopressor | <input type="checkbox"/> Orinase | <input type="checkbox"/> Purinethol | <input type="checkbox"/> Ticagrelor | <input type="checkbox"/> Zanaflex |
| <input type="checkbox"/> Brilinta | <input type="checkbox"/> Dexedrine | <input type="checkbox"/> Flurbiprofen | <input type="checkbox"/> Lovastatin | <input type="checkbox"/> Oxycodone | <input type="checkbox"/> Rabeprazole | <input type="checkbox"/> Timolol | <input type="checkbox"/> Zocor |
| <input type="checkbox"/> Bupropion | <input type="checkbox"/> Dextilant | <input type="checkbox"/> Fluvastatin | <input type="checkbox"/> Mellaril | <input type="checkbox"/> Paliperidone | <input type="checkbox"/> Razadyne | <input type="checkbox"/> Timoptic | <input type="checkbox"/> Zofran |
| <input type="checkbox"/> Bystolic | <input type="checkbox"/> Dexlansoprazole | <input type="checkbox"/> Focalin | <input type="checkbox"/> Mercaptopurine | <input type="checkbox"/> Pamelor | <input type="checkbox"/> Remeron | <input type="checkbox"/> Tizanidine | <input type="checkbox"/> Zolof |
| <input type="checkbox"/> Capecitabine | <input type="checkbox"/> Dexmethylphenidate | <input type="checkbox"/> Galantamine | <input type="checkbox"/> Methadone | <input type="checkbox"/> Pantoprazole | <input type="checkbox"/> Risperdal | <input type="checkbox"/> Tofranil | <input type="checkbox"/> Zyprexa |
| <input type="checkbox"/> Carisoprodol | <input type="checkbox"/> Dextroamphetamine | <input type="checkbox"/> Gilmepiride | <input type="checkbox"/> Methyphenidate | <input type="checkbox"/> Paroxetine | <input type="checkbox"/> Risperidone | <input type="checkbox"/> Tolbutamide | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Carvedilol | <input type="checkbox"/> Diazepam | <input type="checkbox"/> Glipizide | <input type="checkbox"/> Metoprolol | <input type="checkbox"/> Paxil | <input type="checkbox"/> Ritalin | <input type="checkbox"/> Tolterodine | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Glucotrol | <input type="checkbox"/> Mevacor | <input type="checkbox"/> Percocet | <input type="checkbox"/> Rosuvastatin | <input type="checkbox"/> Toviaz | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Celecoxib | <input type="checkbox"/> Dolophine | <input type="checkbox"/> Glyburide | <input type="checkbox"/> Mexiletine | <input type="checkbox"/> Perphenazine | <input type="checkbox"/> Rythmol | <input type="checkbox"/> Tramadol | <input type="checkbox"/> _____ |

7. Physician Signature

I authorize that this test is medically necessary for my patient and I can furnish sufficient documentation in the patient's records showing medical necessity. I affirm that the results will inform a decision with major clinic or non-clinical implications for the patient.

Physician Signature: _____ Date: _____

ADDITIONAL REQUIREMENTS

All Pharmacogenomics orders are REQUIRED to have a wet ink physician signature, medical records, and the "Pharmacogenomics (PGx) Medical Records Documentation" from Qitek's Resources page found under the Pharmacogenomics section.