

Machaon Diagnostics

aHUS Genetic Panel Order Form

STAT Turnaround Time: 48 hours, M-F / Routine Turnaround Time: 1 week

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1-800-566-3462

PATIENT INFORMATION (complete or attach)			SUBMITTING FACILITY		
Patient's Name: (Last, First, M.I.)		Gender: (circle one) M / F	Facility Phone Number: _____ Fax Number for Results: _____		
Specimen Date: (MM/DD/YY) Time: AM / PM		Date of Birth: (MM/DD/YY)			
Medical Record / ID#:		Patient's Social Security #:			
ORDERING PHYSICIAN INFORMATION			BILLING INFORMATION		
Physician's Name: (Last, First, M.I.)		Physician's NPI:	Bill to: <input type="checkbox"/> Facility / Inpatient or Outpatient		
Contact Phone Number:		Fax Number for Results:	Bill to: <input type="checkbox"/> Insurance / Outpatient		
Physician's direct phone number to call results: (highly encouraged)			<input type="checkbox"/> STAT <i>Samples shipped for weekend arrival must be ordered STAT. Mark FedEx Airbill for 'SATURDAY Delivery.'</i>		
CLINICAL INFORMATION (if available)			TEST SELECTION		
ADAMTS-13: _____ (%) Inhibitor: + / -- <i>Note: We offer this test with a 24-hour turnaround time. Please call for draw kits.</i>		Has this patient had a bone marrow transplant? Yes / No / unknown	<input type="checkbox"/> aHUS Genetic Panel		Methodology: Rapid Next Generation sequencing of 20 genes, one SNP
PLT Count: _____ (K/ μ L)	Shiga toxin: + / --	Ecuzilumab therapy: Yes / No	Genes sequenced: ADAMTS13, C2, C3, C3AR1, CD46 (MCP), CFB, CFD, CFH, CFHR1, CFHR2, CFHR3, CFHR4, CFHR5, CFI, DGKE, MASP2, MMACHC, THBD, PLG, WT1 and C5 p.Arg885		
Hemoglobin: _____ (mg/dL)	LDH: _____ (U/L)		<input type="checkbox"/> CFH Autoantibody		Ordered reflexively when associated deletions are identified.
Ethnicity: (circle one) European, African, Latino, East Asian, South Asian or other: _____					
Specimen Collection, Processing and Shipping / call for draw kits (free shipping included)					
1. Draw 1 lavender top tube (EDTA) and store and ship at room temperature.			6. Place all forms into document sleeve of the biohazard bag.		
2. Mix tube by inversion, gently to ensure proper mixing.			7. Ensure that no patient-specific information is visible.		
3. Label tube with patient first and last name, draw date and DOB.			8. Place biohazard bag into the provided FedEx Clinical Pak.		
4. Enclose tube in Styrofoam box and seal in biohazard bag.			9. Complete the provided FedEx Airbill and affix Airbill pouch to Pak.		
5. Complete this form and attach insurance billing information.			10. Call FedEx 800-238-5355 for a pick-up.		
Patient Authorization: Yes / No if you authorize Machaon Diagnostics to use your deidentified laboratory data and sample for research to learn more about this rare disease and facilitate the education of our physician clients.					
OUTPATIENT ONLY: INSURANCE BILLING INFORMATION (complete or attach)					
Insurance Company: (Medicare patients must sign ABN on reverse)			Patient Address:		Patient Phone Number:
Insurance Policy / Medicare Number:		Insurance Group Number:	Patient City:		State: Zip Code:
Insurance Company Address:			Authorization Number:		
Insurance Company City:		State:	Zip Code:		
DIAGNOSIS CODE(S):		(Please complete medical necessity form.)			
ICD-10 Code:	ICD-10 Code:	ICD-10 Code:	Patient's Signature: _____ Date: _____		
ADDITIONAL INFORMATION					
Machaon Diagnostics is a specialized coagulation and platelet laboratory that provides comprehensive clinical evaluations of bleeding and clotting patients. Most evaluations can be completed within 24 hours, 7 days a week. Machaon Diagnostics is a California-licensed, CLIA-accredited, CAP-accredited, clinical laboratory approved to provide high-complexity testing services. This test is not covered or reimbursed by Medicare or Medicaid. All patients are considered OUT-OF-NETWORK and will be billed for services not covered by their insurance provider. Medicare patients must sign an ABN, either located on the reverse side of this form or downloaded from the Machaon Diagnostics website. Patient insurance billing services are provided in accordance with the Machaon Insurance Billing Policy. HMO or medical group covered patients may need a prior authorization if they seek full reimbursement. For more information please visit www.MachaonDiagnostics.com or call (510) 839-5600.					