

Machaon Diagnostics

coagulation, platelets, rare disease and genetics
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HLH Genetic Panel 3.0 Order Form

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

MachaonDiagnostics.com
 1-800-566-3462

PATIENT INFORMATION (complete or attach)			SUBMITTING FACILITY		
Patient's Name: (Last, First, M.I.) <i>required</i>		Gender: <i>required</i> M F	Facility Name and Address: <i>required</i>		
Specimen Date and Time: <i>required</i>		DOB: (MM/DD/YYYY) <i>required</i>	Facility Phone Number: <i>required</i> Fax Number for Results: <i>required</i>		
MRN: <i>required</i>		Accession #: <i>required</i>			
ORDERING PHYSICIAN INFORMATION			BILLING INFORMATION		
Physician's Name: (Last, First, M.I.) <i>required</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		Please inquire with our patient advocates regarding insurance coverage for this test.
Physician's direct phone number to call results: (<i>highly encouraged</i>)			<input type="checkbox"/> STAT STAT required for 48-hour turnaround time, M-F		
CLINICAL INFORMATION (if available)			TEST SELECTION		
soluble IL-2R (CD25): _____ (U/mL) Ferritin: _____ (ng/mL) Triglycerides: _____ (mg/dL)		Has this patient had an allogeneic bone marrow transplant? Yes No unknown	<input type="checkbox"/> HLH Genetic Panel 3.0		Reflex negative and equivocal results to extended panel.
Hemophagocytosis: Present Not present NK Function: _____ (%)		Neutrophil count: _____ (K/ μ L) Platelet count: _____ (K/ μ L)	32 genes included: ADA, AP3B1, AP3D1, CD27, CD70, CDC42, CTP51, CYBA, CYBB, CYBC1, GATA2, HAVCR2, IL2RG, ITK, LIPA, LYST, MAGT1, NCF2, NCF4, NCKAP1L, NLRC4, PRF1, RAB27A, RASGRP1, RC3H1, RHOG, SH2D1A, SLC7A7, STX11, STXB2, UNC13D, XIAP and UNC13D 253-kb inversion; 9 additional genes included in the extended panel: FADD, FAS, FASLG, MEV9, MVK, NLRP3, STAT1, TNFRSF1A and WAS.		
Ethnicity: European African Latino East Asian South Asian or other: _____					
Informed Consent for Genetic Testing (required for patients drawn in New York state)					
<p>Providers are required to obtain informed consent from patients for genetic testing for all genetic samples originating in New York. An informed consent form may be found at www.machaondiagnosics.com, with a description of the test, purpose, and limitations. In lieu of submitting a copy of the signed informed consent, healthcare providers may sign the below statement attesting that informed consent has been obtained.</p> <p>Verification of Informed Consent: I am a healthcare provider for the patient named on this requisition. I have obtained the required informed consent from the patient or the patient's legal guardian for each genetic test ordered on this requisition and I authorize testing of the provided specimen.</p> <p>Signature of Provider _____ Date: _____</p> <p><i>Note: testing may be delayed if a consent form is not received or the provider signature is not present.</i></p>					
OUTPATIENT ONLY: INSURANCE BILLING INFORMATION (complete or attach)					
Insurance Company: (<i>Medicare patients must sign ABN on reverse</i>)		Patient Address:		Patient Phone Number:	
Insurance Policy / Medicare Number:		Insurance Group Number:		Patient City:	State: Zip Code:
Insurance Company Address:		Authorization Number:		OUTPATIENT ONLY: PATIENT SIGNATURE Machaon Diagnostics may need to obtain additional information from your physician to complete these services. I hereby authorize the release of medical information related to the services described herein and authorize payment directly to Machaon Diagnostics. Please inquire with our patient advocates regarding insurance coverage for this test. The HLH Genetic Panel is \$3,127 and if ordered STAT, add \$770; shipping charges may apply. I agree to assume responsibility for payment of all charges not covered by my healthcare insurer.	
Insurance Company City:		State:	Zip Code:		
DIAGNOSIS CODE(S):		<i>(Please complete medical necessity form.)</i>			
ICD-10 Code:	ICD-10 Code:	ICD-10 Code:	Patient's Signature:		Date:
ADDITIONAL INFORMATION 					