PrenatalDetect RHD

Test Requisition Form

Dvysr®
Devyser Genomic Laboratories

1. Patient Information

First Name: _____ **Last Name:** _____

Street Address: _____ **Apt/Unit/Suite:** _____

City: _____ **State:** _____ **Zip Code:** _____

DOB (MM/DD/YYYY): _____

SAB: Male Female

MRN/Patient ID: _____ **Collection Date (MM/DD/YYYY):** _____

Maternal Weight: _____ **Maternal Height:** _____

Race: White Black Hispanic Asian/Pacific North American Native Other

2. Provider / Client Information

Facility Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Qualified Healthcare Provider: _____

Phone: _____ **Email:** _____ **Fax:** _____

Treatment Provider: _____

Phone: _____ **Email:** _____ **Fax:** _____

Provider Authorization

This requisition constitutes an order for molecular testing from **Devyser Genomic Laboratories.** I certify (a) the services are medically necessary and will assist me in treating my patient, (b) I maintain and will make available patient medical records documenting the foregoing, (c) I have supplied information to the patient regarding this testing and the patient has consented to genetic testing. Regarding patient consent, the ordering physician will be solely responsible for confirming that legally effective informed consent has been obtained from the patient or his/her authorized representative as required by applicable state law. By ordering a test from **Devyser Genomic Laboratories.** the physician certifies that this consent is in place and that test results will be used and disclosed only in accordance with applicable law. I have signed statements on file from the patient and in accordance with your practice or institution permitting you and your contracted vendors to release data to other organizations to adjudicate claims.

First Name: _____ **Last Name:** _____ **Provider 10-Digit NPI #:** _____

Signature: _____

3. Select Test

PrenatalDetect RHD

4. Clinical Indications

Pregnant: Yes No **Estimated Due Date (MM/DD/YYYY):** _____ **Pregnancy Details (If applicable):** Twins Triplets or Higher

ICD-10 Codes: Z31.82 Encounter for Rh incompatibility status Other: _____

Sending client has confirmed the mother is Rh-negative: Yes No

PrenatalDetect RHD

Test Requisition Form

Dvysr®
Devyser Genomic Laboratories

5. Billing/Insurance Information

Inpatient	<14 Days after discharge	Client/Institution Billing	Medicare/Advantage
Outpatient	>14 Days after discharge	Private Insurance	Medicaid

Attach copy of front & back of insurance card or face sheet

Insurance Co. Name: _____ **Member ID:** _____ **Group ID:** _____

Relation: Self Spouse Dependent Other: _____

Policy Holder Name: _____ **Policy Holder DOB (MM/DD/YYYY):** _____

Specimen

Whole Blood (EDTA)

Volume/Amount

> 6mL

Container

EDTA collection tube (Lavender Top)

Additional information

Samples can be stored refrigerated (2 to 8°C). Do not freeze. Samples must be received within 6 days after collection.

Before you ship, please make sure that:

1. Test Panel and ICD-10 codes are selected
2. Required fields on this form are complete
3. Insurance card copies are included
4. Requisition is signed.

Shipping Address

Devyser Genomic Laboratories
11660 Alpharetta Highway
Suite 700 Office 770
Roswell, GA 30076

Contact Information

Email: laboratorysupport@us.devyser.com
Phone: 1 (877) 338-9737