

Client Information (required)

Client Name		
Client Account No.		
Client Phone	Client Order No.	
Address		
City	State	Zip Code

Submitting Provider/Provider Name Information (required)

Submitting/Referring Provider <i>(Last, First)</i>
Fill in only if Call Back is required. Phone () _____ - _____ Fax * () _____ - _____
Provider's National I.D. (NPI)

**Fax number given must be from a fax machine that complies with applicable HIPAA regulation.*

Reason for Referral (required)

ICD-10 Diagnosis Code

Note: It is the client's responsibility to maintain documentation of the order.
New York State Patients: Informed Consent for Genetic Testing

<p>"I hereby confirm that informed consent has been signed by an individual legally authorized to do so and is on file with this office or the individual's provider's office."</p> <p>Signature _____</p>

Note: It is the client's responsibility to maintain documentation of the order.

Ship specimens to:

Mayo Clinic Laboratories
3050 Superior Drive NW
Rochester, MN 55901

Customer Service: 855-516-8404

Visit www.MayoClinicLaboratories.com for the most up-to-date test and shipping information.

Patient Information (required)

Patient ID <i>(Medical Record No.)</i>		
Patient Name <i>(Last, First, Middle)</i>		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date <i>(Month DD, YYYY)</i>	
Collection Date <i>(Month DD, YYYY)</i>	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Patient's Street Address		
Phone		
City	State	Zip Code

Insurance Information (required)

Subscriber's Name <i>(if different than patient)</i>		
Patient Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____		
Medicare HIC Number <i>(if applicable)</i>		
Medicaid Number <i>(if applicable)</i>		
Insurance Company's Name <i>(if applicable)</i>		
Insurance Company's Street Address		
City	State	Zip Code
Policy Number		
Group Number		

MCL Internal Use Only

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Billing Information

- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing related questions:
800-447-6424 (US and Canada)
507-266-5490 (outside the US)

Patient Information (required)

Patient ID <i>(Medical Record No.)</i>	Client Account No.
Patient Name <i>(Last, First, Middle)</i>	Client Order No.
Birth Date <i>(Month DD, YYYY)</i>	

BIOMARKER PANELS	
<input type="checkbox"/> CVRMP	Cardiovascular Risk Marker Panel, Serum
NOHDL	Non-HDL Cholesterol
CALDL	Calculated LDL
HDCDC	HDL Cholesterol, CDC, Serum
TCCDC	Cholesterol, Total, CDC, Serum
TGCD1	Triglycerides, Total, CDC, Serum
CVINT	Interpretation
LIPA	Lipoprotein (a), Serum
HSCR	C-Reactive Protein, High Sensitivity, Serum
<input type="checkbox"/> LMPP	Lipoprotein Metabolism Profile
TCS	Cholesterol, Total, CDC, Serum
TRIGC	Triglycerides, CDC, Serum
APLBS	Apolipoprotein B, Serum
HDLS	HDL Cholesterol, CDC, Serum
LMPP1	Lipoprotein Metabolism Profile 1

LIPIDS AND LIPOPROTEINS	
<input type="checkbox"/> APABR	Apolipoprotein A1 and B, Plasma
<input type="checkbox"/> APLA1	Apolipoprotein A1, Plasma
<input type="checkbox"/> APLB	Apolipoprotein B, Plasma
<input type="checkbox"/> CERAM	Ceramides, Plasma
<input type="checkbox"/> HDCH	Cholesterol, High-Density Lipoprotein (HDL), Serum
<input type="checkbox"/> CHOL	Cholesterol, Total, Serum
<input type="checkbox"/> CHLE	Cholesteryl Esters, Serum
<input type="checkbox"/> NEFA	Free Fatty Acids, Total, Serum
<input type="checkbox"/> TGGB	Glycerol-Corrected Triglycerides, Serum
<input type="checkbox"/> LDLD	LDL Cholesterol (Beta-Quantification), Serum
<input type="checkbox"/> LPAWS	Lipoprotein (a) Cholesterol, Serum
<input type="checkbox"/> LIPA	Lipoprotein (a), Serum
<input type="checkbox"/> PPL	Phospholipids, Serum
<input type="checkbox"/> TRIG	Triglycerides, Serum

INFLAMMATION	
<input type="checkbox"/> ADMA	Asymmetric Dimethylarginine, Plasma
<input type="checkbox"/> CFIBR	Cardiac Fibrinogen, Plasma
<input type="checkbox"/> HSCR	C-Reactive Protein, High Sensitivity, Serum
<input type="checkbox"/> CYSTC	Cystatin C with Estimated GFR, Serum
<input type="checkbox"/> F2ISO	F2-Isoprostanes, Urine
<input type="checkbox"/> HCYSS	Homocysteine, Total, Serum

HEART FAILURE	
<input type="checkbox"/> ALDS	Aldosterone, Serum
<input type="checkbox"/> ACE	Angiotensin Converting Enzyme, Serum
<input type="checkbox"/> BNP	B-Type Natriuretic Peptide (BNP), Plasma
<input type="checkbox"/> GAL3	Galectin-3, Serum
<input type="checkbox"/> PBNP	NT-Pro B-Type Natriuretic Peptide (BNP), Serum
<input type="checkbox"/> PRA	Renin Activity, Plasma
<input type="checkbox"/> NACCL	Sodium, Serum
<input type="checkbox"/> ST2S	ST2, Serum
<input type="checkbox"/> TPNI	Troponin I, Serum
<input type="checkbox"/> TRPS	Troponin T, 5th Generation, Plasma

GENETICS	
Next-Generation Sequencing Panels	
<input type="checkbox"/> ARVGP	Arrhythmogenic Cardiomyopathy Multi-Gene Panel, Blood
<input type="checkbox"/> BRGGP	Brugada Syndrome Multi-Gene Panel, Blood
<input type="checkbox"/> CCMGP	Comprehensive Cardiomyopathy Multi-Gene Panel, Blood
<input type="checkbox"/> DCMGP	Dilated Cardiomyopathy Multi-Gene Panel, Blood
<input type="checkbox"/> FHRGP	Familial Hypercholesterolemia and Related Disorders Multi-Gene Panel
<input type="checkbox"/> HHTGP	Hereditary Hemorrhagic Telangiectasia Gene Panel
<input type="checkbox"/> HCMGP	Hypertrophic Cardiomyopathy Multi-Gene Panel, Blood
<input type="checkbox"/> LQTGP	Long QT Syndrome Multi-Gene Panel, Blood
<input type="checkbox"/> MFRGP	Marfan Syndrome and Related Disorders Multi-Gene Panel, Varies
<input type="checkbox"/> NSRGP	Noonan Syndrome and Related Disorders Multi-Gene Panel, Blood
Postmortem NGS Panels	
<input type="checkbox"/> PMARP	Postmortem Arrhythmia Panel
<input type="checkbox"/> PMCMP	Postmortem Cardiomyopathy Panel
<input type="checkbox"/> PMMFR	Postmortem Marfan and Related Panel
<input type="checkbox"/> PMNSR	Postmortem Noonan and Related Panel
Single Gene Analysis	
<input type="checkbox"/> FBN1B	FBN1 Full Gene Sequence, Varies
Cytogenetics	
<input type="checkbox"/> DD22F	22q11.2 Deletion/Duplication, FISH
Known Variant Analysis	
<input type="checkbox"/> KVAR1	Known Variant Analysis-1 Variant
<input type="checkbox"/> KVAR2	Known Variant Analysis-2 Variants
<input type="checkbox"/> KVAR3	Known Variant Analysis-3+ Variants

PHARMACOGENOMICS	
<input type="checkbox"/> 2C19V	Cytochrome P450 2C19 Genotype
<input type="checkbox"/> 2D6CV	Cytochrome P450 2D6 (CYP2D6) Comprehensive Cascade
<input type="checkbox"/> 3A4V	Cytochrome P450 3A4 Genotype
<input type="checkbox"/> PGXFP	Focused Pharmacogenomics Panel
<input type="checkbox"/> SLC1V	Solute Carrier Organic Anion Transporter Family Member 1B1 (SLC01B1) Genotype, Statin
<input type="checkbox"/> WARSV	Warfarin Response Genotype

PHARMACOLOGY	
<input type="checkbox"/> FRDIG	Digoxin, Free, Serum
<input type="checkbox"/> DIG	Digoxin, Serum
<input type="checkbox"/> IMIPR	Imipramine and Desipramine, Serum
<input type="checkbox"/> WRF	Warfarin, Serum

PROTEOMICS	
<input type="checkbox"/> AMPIP	Amyloid Protein Identification, Paraffin, LC-MS/MS

ANATOMIC PATHOLOGY	
<input type="checkbox"/> ANPAT	Anatomic Pathology Consultation, Wet Tissue*
<input type="checkbox"/> MDM2F	MDM2 (12q15) Amplification, Well-Differentiated Liposarcoma/Atypical Lipomatous Tumor, FISH, Tissue
<input type="checkbox"/> DDITF	Myxoid/Round Cell Liposarcoma, 12q13 (DDIT3 or CHOP) Rearrangement, FISH, Tissue
<input type="checkbox"/> SS18F	Synovial Sarcoma (SS), 18q11.2 (SS18 or SYT) Rearrangement, FISH, Tissue
<input type="checkbox"/> SYT	Synovial Sarcoma by Reverse Transcriptase PCR (RT-PCR)

ADDITIONAL TESTS (INDICATE TEST NUMBER AND NAME)	

*This test will reflex to other types of pathology consults (eg, outside slide) and stains as needed.