

GENETIC TESTING PRESCRIBER ORDER FORM				
Patient Name:			DOB:	
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information				
Primary Diagnosis Description:			ICD-10 Code:	
Prescription				
Decode DEB Sponsored Testing Program through PreventionGenetics. Test Code: 1578727 Genes: CD151, CDSN, CHST8, COL17A1, COL7A1, CSTA, DSG1, DSP, DST, EXPH5, FERMT1, ITGA3, ITGA6, ITGB4, JUP, KLHL24, KRT1, KRT10, KRT14, KRT5, LAMA3, LAMB3, LAMC2, PKP1, PLEC, SERPINB8, TGM5 *Separate test requisition necessary for ordering.*				
Nursing Orders				
Skilled nurse to make one-time home visit for testing completion. Genetic testing kit supplied by PreventionGenetics to be administered per package instructions and returned same day via mailing instructions.				
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's results and treatment.</i>				
Prescriber Signature:			Date:	
Prescriber Information				
Prescriber Name:		Phone:	Fax:	
Address:		NPI:		
City, State:	Zip:	Office Contact:		
Fax completed form and PreventionGenetics order form: (800) 491-9561 or eFax-VyjuvekReferral@optioncare.com				
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