

GENETIC TESTING PRESCRIBER ORDER FORM				
Patient Name:		DOB:		Gender:
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				
<p><b>Decode DEB Sponsored Testing Program through PreventionGenetics. Test Code: 1578727</b></p> <p>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</p> <p>*Separate test requisition necessary for ordering.*</p>				
Nursing Orders				
<p>Skilled nurse to make one-time home visit for testing completion.</p> <p>Genetic testing kit supplied by PreventionGenetics to be administered per package instructions and returned same day via mailing instructions.</p> <p>If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.</p>				
<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:	
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