

CeliacDx Genetics Testing Requisition Form



PATHOLOGY
REFERENCE LABORATORY

Fax to (210) 236-5248

PATIENT INFORMATION

Name: _____ Address 1: _____
First MI Last

Date of Birth: _____ Address 2: _____
mm/dd/yyyy

Sex (Male, Female): _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Sample Collection Date: _____
mm/dd/yyyy

Symptoms: Intestinal Extra-intestinal None
Family History: Positive Negative Unknown
Gluten Consumption > Six Weeks: Yes No

PATIENT INSURANCE INFORMATION

PLEASE PROVIDE FRONT & BACK COPY OF INSURANCE CARD.

Check one:

HMO, PPO, Commercial Insurance
Please fill out the fields below OR provide a copy of the front and back of insurance card.

Provider: _____ Policy #: _____

Policyholder: Self Other: _____
Relationship to Patient (e.g., "Spouse," "Parent")

Name: _____
Policyholder Info (if Other)

Date of Birth: _____ Sex (Male, Female): _____

Medicare / Medicaid
Please fill out the fields below OR provide a copy of the front & back of insurance card.

Subscriber ID: _____

Cash Pay - Patient will be billed \$199 directly via mail.

An insurance claim will be filed on behalf of the patient. Patients with private insurance will receive a bill for any open balance after claim adjudication. Patients with Medicare or Medicaid may be billed for copays, coinsurance, or deductibles as per payer guidelines.

PRESCRIBER INFORMATION

Kit Delivery Method: We request kit delivery directly to the patient address We request collection kit delivery to our clinic address

Prescriber or Clinic Account Name: _____ Address 1: _____

NPI: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____

DELIVER TEST RESULTS TO: _____
Enter Email

_____ Enter Fax Number

LABORATORY TEST ORDERED

CeliacDxTesting

HLA-DQ2/DQ8
CPT code: 2x 81382
FDA Cleared Celiac Genetic Testing by next generation sequencing (NGS) with Pathology Review of Genetic Results
Please include copies of any previous antibody or biopsy test results.

TESTING LABORATORY

Celiac disease genetic testing will be conducted by PacificDx Laboratory in Irvine CA. A board certified pathologist will interpret results.

ICD-10 DIAGNOSIS CODE (REQUIRED)

R90.0 (Celiac Disease) **R19.7** (Diarrhea unspecified) **K59.0** (Constipation)

R10.9 (Abdominal pain) **R14.0** (Bloating) **Other:** _____

PRESCRIBER SIGNATURE (REQUIRED)

As the ordering prescriber named above, I certify that the patient whose specimen is being submitted for analysis has been informed of the benefits and limitations of the laboratory test(s) requested, has had the opportunity to have all questions answered adequately, and, if required by my institution, has given informed consent.

SIGN HERE _____ DATE _____
PRESCRIBER SIGNATURE



5 Mason, Suite 100, Irvine, CA 92618
Laboratory Director: Shelly Gunn, MD, PhD