RPhLABS

COLA ID: 33822 CLIA ID: 45D2288954 HIPAA COMPLIANT

BARCODE

(888) 383-2181 (888) 382-2181 hello@rphlabs.com www.rphlabs.com 8230 Elmbrook Drive, Suit 200 Dallas, Texas, 75247

1 Patient Information

First Name ______ Last Name ______

DOB (MM/DD/YYYY) ______ Gender ☐ Male ☐ Female ☐ Other Language ______

Street Address ______

City/State/Zip ______ Email ______ Phone ______

Ancestry ☐ African American ☐ Hispanic ☐ East Asian ☐ Caucasian ☐ Pacific Islander ☐ South Asian ☐ Native American ☐ North African ☐ Other

2 Medical History

Diagnosis Code:

Current Medication(s):

Considering Medication(s):

3 PGx Test

PGx Test Information

Current RX or Considering RX: Please put a check mark next to the medications you want to order a test on in either Current RX indicating that you are currently prescribing the medication or Considering RX if you are evaluating the medication for the patient.

ICD10: Please put the diagnosis code that is the reason for the current/considered RX.

Test Information

☐ ABCG2	☐ BCHE	☐ CYP2C19	☐ CYP2D6	☐ CYP3A5	☐ DPYD	☐ NAT2	☐ RNR1	☐ TPMT	☐ UGT1A1
☐ APOE	☐ CYP2B6	☐ CYP2C9	☐ CYP3A4	☐ CYP4F2	☐ G6PD	☐ NUDT15	☐ SLCO1B1	☐ UGT2B17	☐ VKORC1

Specimen Information

Date of Collection: ______ Time: ______ ☐ AM ☐ PM

Specimen Type: ☐ Buccal Swab Collector: ______

Specimen Labeling Information

1. Label each specimen tube with:
   - Patient's full name • Date of birth • Collection date
2. Ship the specimen along with the completed TRF. Contact **hello@RPhlabs.com** for sample kits.

Specimen requirements and shipping guidelines can be found at: www.rphlabs.com

4 Financial Responsibility

Select the payment option: ☐ Self-Pay ☐ Payment made on Website ☐ Bill to Provider

Credit Card Information (If Self-Pay)

☐ Visa ☐ Mastercard ☐ American Express ☐ Discover ☐ HSA (Health Savings Account) ☐ FSA (Flexible Spending Account)

Name on Card ______ Card Number ______

Expiry Date ______ (MM/YY) CVV/CVC/Security Code ______

ACH Bank Transfer Information:

Account Holder Name ______ Account Type: ☐ Checking ☐ Saving

Routing No # ______ Account No # ______

Provide your email address to receive a secure Stripe payment link: ______ (Your Email).

5 Prescriber Information

Prescriber's Name ______ Office Contact Name ______

NPI # ______ Physician License Number ______ Phone ______ Fax ______

Address ______ City/State/Zip ______

Date (MM/DD/YYYY) ______ Prescriber Signature ______

Disclaimer:

By signing this form, the patient and/or authorized prescriber certifies the accuracy of the information provided and authorizes RPhLabs to perform the requested testing. Test results are for use by a licensed healthcare provider only, and the responsible party acknowledges financial responsibility for applicable charges.