

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

Requested PGx Test

PGx Gene Test:

Select Gene to Test

Test for ALL gene's listed below

- ABCG2 BCHE CYP2C19 CYP2D6 CYP3A5 CYP4F2 G6PD NAT2 SLCO1B1 UGT1A1
 APOE CYP2B6 CYP2C9 CYP2C CYP3A4 DPYD MT-RNR1 NUDT15 TPMT VKORC1

4

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.