Noninvasive DNA Test For Drug Sensitivity

All tests are subject to ABN - Instructions located on the bottom of requisition

Test Request

☐ **Med Management**

☐ **MTHFR**

An enzyme that helps process folate which plays an important role in DNA synthesis and regulation of homocysteine levels. Certain mutations in the gene coding for MTHFR produce an enzyme that has reduced activity. Reduced activity can lead to elevated levels of homocysteine when folate levels are low which is associated with increased cardiovascular risk. Patients who are initiating folate or methotrexate therapies or have a history of adverse effects or treatment failure should consider MTHFR genotyping. Certain variants of MTHFR are associated with improved central nervous system treatment outcomes with adjunctive L-methylfolate treatment.

Patient Information

Patient Name _____
(First Name, Last Name)

Address _____

City _____ State _____ Zip _____

Phone # _____ SS# _____

Date of Birth ____ /____ /_____ Gender: ☐ Male ☐ Female

Race/Ethnic Identification: ☐ African-American ☐ Asian
☐ Caucasian ☐ Hispanic ☐ Other _____

Drug Allergy(ies): ☐ NKA _____

Current Medications _____

_____

Prescribing New Rx (list medication): _____

Physician Information

Practice Name _____

Physician Name _____

Office Phone _____

Name of office contact: _____

Check at least one box below for result delivery for this test:

☐ **Fax:** (____) _____ - _____ ☐ **Secure Portal**

Physician / Authorizing Medical Professional's Signature

X _____

Payment

This is a self pay test that is managed through EBM Medical.

Patient Consent: I request and authorize the CLIA accredited laboratory to perform the above designated test(s) on the DNA sample provided by me. My signature below constitutes my acknowledgment that I have read the Informed Consent for Molecular Genetic Testing which outlines the benefits and limitations of this testing which have been explained to my satisfaction by a qualified health professional.

Consentimiento del Paciente: Solicito y autoriso que el laboratorio acreditado por CLIA para que realice las pruebas de ADN designadas en la parte superior de esta requisicion, sometidas por mí persona. Mi firma constituye el reconocimiento que he leído el formulario de información del paciente que describe los beneficios y limitaciones de esta prueba que han sido explicados a mi satisfacción por un profesional de la salud.

Patient Signature: _____

Ship samples to:

GENETWORx
4060 Innslake Drive
Glen Allen, VA 23060

IMPORTANT: Please write patient name and DOB on the patient samples

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