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For the person in every patient®

## **Physician / Account Information**

ACCOUNT NAME / ADDRESS

## **TEST REQUISITION**

PLEASE PRINT

Laboratory / Account Information	PHONE
DATE COLLECTED (required):	PHYSICIAN / NPI#
TIME COLLECTED:	
PATIENT ID#	
SENDER SAMPLE ID#	
SAMPLE DRAWN AT:	
LABORATORY NAME / ADDRESS St. Rita's Medical Center (New Vision Laboratory) 750 West High Street 4th Floor	ICD-9 CODES (required)
Lima, OH 45801 US	
PHONE FAX	CLINICAL DIAGNOSIS
CONTACT (419) 226-9762 (419) 226-9756	
RESULTS Mail	CHECK THE APPRO (Specimen co
Patient Information (required)	□PROMETHEUS® IB
LAST NAME	Includes 7 tests: ASCA IgA, A: IFA perinuclear pattern, IFA D
FIRST NAME MI	Add PROMETHEUS® Celia indicates non-IBD
ADDRESS	Add PROMETHEUS® Crohi
CITY STATE ZIP	□PROMETHEUS® Cr
HOME PHONE NUMBER	Includes the following: ASCA IFA perinuclear pattern, IFA D
OTHER PHONE NUMBER	□ PROMETHEUS® Ce
DOB SEX DM DF SSN	Includes both antibody and • tTg IgA • EMA IgA • Tota
Billing Information (required)	PROMETHEUS® Ce Celiac genetic assessment HL
BILL: □ Account □ Insurance □ Laboratory □ Patient □ Medicare: We will submit claims to Medicare for most of our services, but only for patients who are neither hospital inpatients nor hospital outpatients, for whom the hospital must submit a claim.  Medicare requires the signature of the ordering physician for all clinical laboratory tests.	□ PROMETHEUS® Ce includes the following: □ Anti-human tissue transglu □ Anti-endomysial IgA - #150 □ DGP Antibody IgA - #1255
I certify that the ordered test(s) is(are) reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition.	PROMETHEUS® TF Genotype patients for individ
Ordering Physician's Signature Date	Phenotype patients for indivi
Print Name  PRIMARY INSURANCE: As a courtesy, we will bill your insurance. Please attach a copy (front and back) of insurance card(s) and complete all information below. NOTE: Parent or guardian information required if patient is a minor. Parent or guardian is responsible for payment.	□ PROMETHEUS® Th Thiopurine metabolite (6-TGN Optimize ongoing dosing of th Current therapeutic: □ 6-MP
NAME OF PARENT OR GUARDIAN (IF PATIENT IS UNDER 18 YEARS OF AGE)	□ PROMETHEUS® <b>FIBROS</b>
INSURANCE CARRIER	PROMETHEUS® Serum I
POLICY NUMBER	E ETROMETICOS Serdiff IIIIII
GROUP NAME	PROMETHEUS* Lacto 7)  BreathTek™ UBT - #1202  DOB¹  Pequired for patients < 18 years
GROUP NUMBER	BreathTek™ UBT - #1202
ADDRESS	DOB <sup>†</sup> †Required for patients < 18 years
CITY STATE ZIP	- Negariou for patients vilo years
PHONE FAX	☐ Other Prometheus Tests
POLICYHOLDER NAME	GENETIC CONSENT  * My signature below indicates the
POLICYHOLDER ID# (SSN)	form on the back page.
POLICYHOLDER DOB RELATION TO PATIENT	Physician Signature:
POLICYHOLDER PHONE	Patient/Guardian Signature:
SECONDARY INSURANCE: Attach a copy (front and back) of the secondary insurance card. Provide the insurance name, policy number and group name, billing address and phone, policyholder name, ID#, date of birth, relation to patient, and phone number.	BreathTek™ UBT is a trademark of Meretek PROMETHEUS, the Link Design, For the pe or registered trademarks of Prometheus La©2010 Prometheus Laboratories Inc. All rigit Prometheus products and services may be applied to the product of the product
PREAUTH/REFERENCE #:	available at www.prometheuslabs.com

	PHONE FAX	
	PHYSICIAN / NPI#	
	ICD-9 CODES (required)	
	CLINICAL DIAGNOSIS	
	CHECK THE APPROPRIATE TEST(S) TO BE PERFORMED  (Specimen collection requirements on back)	
□ PROMETHEUS® IBD Serology 7 - #1007		
Includes 7 tests: ASCA IgA, ASCA IgG, Anti-OmpC IgA, Anti-CBirl, ANCA ELISA, IFA perinuclear pattern, IFA DNase sensitivity		
Add PROMETHEUS* Celiac Serology if PROMETHEUS IBD Serology 7 indicates non-IBD  Add PROMETHEUS* Crohn's Prognostic if PROMETHEUS IBD Serology 7		
	Includes the following: ASCA IgA, ASCA IgG, Anti-OmpC IgA, Anti-CBir1, Anti-I2, IFA perinuclear pattern, IFA DNase sensitivity, NOD2/CARD 15	
	□ PROMETHEUS® <b>Celiac PLUS</b> - #6355*	
Includes both antibody and genetic tests with risk stratification  • tTg IgA • EMA IgA • Total Serum IgA • DGP IgA • DGP IgG • HLA DQ2/DQ8		
	□ PROMETHEUS® <b>Celiac Genetics</b> - #6201 (Genetics only)* Celiac genetic assessment HLA DQ2/DQ8 with risk stratification	
□ PROMETHEUS® <b>Celiac Serology</b> - #1155 (Serology only) includes the following:		
	□ Anti-human tissue transglutaminase (Hu-tTG) IgA recombinant antigen - #1405 □ Anti-endomysial IgA - #1505 □ Total serum IgA - #1605	
	□ DGP Antibody IgA - #1255 □ DGP Antibody IgG - #1355	
	□ PROMETHEUS® <b>TPMT Genetics</b> - #3300* Genotype patients for individualized starting dose of thiopurines	
September 1	□PROMETHEUS® <b>TPMT Enzyme</b> - #3320	
<b>Selected Selection</b>	Phenotype patients for individualized starting dose of thiopurines	
A400	□ PROMETHEUS® <b>Thiopurine Metabolites</b> - #3200 Thiopurine metabolite (6-TGN, 6-MMPN) levels	
2004.840.0	Optimize ongoing dosing of thiopurines to reach and maintain therapeutic goal Current therapeutic:     6-MPmg/day   DAZAmg/day   Othermg/day	
	□ PROMETHEUS* <b>FIBRO</b> Spect* <b>II</b> - #4000	
1	PROMETHEUS* Serum Infliximab/HACA Measurement - #3130  PROMETHEUS' Serum Infliximab measurement (only) - #3120	
	□ PROMETHEUS* Lacto <i>TYPE</i> * - #6100*	
5	☐ BreathTek™ UBT - #1202	
ACCIDION A	DOB† Height† Weight†	
	*Required for patients < 18 years of age.	
	Other Prometheus Tests	
F	NETIC CONSENT	
	NETIC CONSENT y signature below indicates that I have read and understood the entire consent	

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\_\_\_ Date: \_\_\_

Date: