PROMETHEUS®
Therapeutics & Diagnostics
For the person in every patient®

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www.prometheuslabs.com

TEST REQUISITION

PLEASE PRINT

Laboratory / Account Information

DATE COLLECTED (required):

TIME COLLECTED:

PATIENT ID#

SENDER SAMPLE ID#

SAMPLE DRAWN AT: ☐ **Hospital Inpatient** ☐ **Hospital Outpatient** ☐ **Other**

LABORATORY NAME / ADDRESS

St. Rita's Medical Center (New Vision Laboratory)
750 West High Street
4th Floor
Lima, OH 45801 US

PHONE (419) 226-9762 FAX (419) 226-9756

CONTACT

RESULTS X ☐ Mail ☐ Fax ☐ No results to lab

Patient Information (required)

LAST NAME

FIRST NAME MI

ADDRESS

CITY STATE ZIP

HOME PHONE NUMBER

OTHER PHONE NUMBER

DOB SEX ☐ M ☐ F SSN

Billing Information (required)

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.**

I certify that the ordered test(s) is(are) reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition.

Ordering Physician's Signature Date

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.**

NAME OF PARENT OR GUARDIAN (IF PATIENT IS UNDER 18 YEARS OF AGE)

INSURANCE CARRIER

POLICY NUMBER

GROUP NAME

GROUP NUMBER

ADDRESS

CITY STATE ZIP

PHONE FAX

POLICYHOLDER NAME

POLICYHOLDER ID# (SSN)

POLICYHOLDER DOB RELATION TO PATIENT

POLICYHOLDER PHONE

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.

PREAUTH/REFERENCE #:

Physician / Account Information

ACCOUNT NAME / ADDRESS

PHONE FAX

PHYSICIAN / NPI #

ICD-9 CODES (required)

CLINICAL DIAGNOSIS

CHECK THE APPROPRIATE TEST(S) TO BE PERFORMED
(Specimen collection requirements on back)

IBD

☐ PROMETHEUS® **IBD Serology 7** - #1007
Includes 7 tests: ASCA IgA, ASCA IgG, Anti-OmpC IgA, Anti-CBir1, 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** indicates Crohn's Disease **(Requires EDTA/Lavender Top Tube and Serum Tube)**

☐ PROMETHEUS® **Crohn's Prognostic** - #2000*
Includes the following: ASCA IgA, ASCA IgG, Anti-OmpC IgA, Anti-CBir1, Anti-I2, IFA perinuclear pattern, IFA DNase sensitivity, NOD2/CARD 15

CELIAC

☐ PROMETHEUS® **Celiac PLUS** - #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® **Celiac Genetics** - #6201 (Genetics only)*
Celiac genetic assessment HLA DQ2/DQ8 with risk stratification

☐ PROMETHEUS® **Celiac Serology** - #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

THIOPURINE MGMT

☐ PROMETHEUS® **TPMT Genetics** - #3300*
Genotype patients for individualized starting dose of thiopurines

☐ PROMETHEUS® **TPMT Enzyme** - #3320
Phenotype patients for individualized starting dose of thiopurines

☐ PROMETHEUS® **Thiopurine Metabolites** - #3200
Thiopurine metabolite (6-TGN, 6-MMPN) levels
Optimize ongoing dosing of thiopurines to reach and maintain therapeutic goal
Current therapeutic: ☐ 6-MP___mg/day ☐ AZA___mg/day ☐ Other___mg/day

ADDITIONAL TESTS

☐ PROMETHEUS® **FIBRO*Spect*® II** - #4000

☐ PROMETHEUS® **Serum Infliximab/HACA Measurement** - #3130
☐ PROMETHEUS® Serum Infliximab measurement (only) - #3120

☐ PROMETHEUS® **Lacto*TYPE*®** - #6100*

☐ **BreathTek™ UBT** - #1202

DOB† Height† Weight†

†Required for patients < 18 years of age.

☐ Other Prometheus Tests

GENETIC CONSENT

* My signature below indicates that I have read and understood the entire consent form on the back page.

Physician Signature: Date:

Patient/Guardian Signature: Date: