Genetics Test Requisition

MOLECULAR VISION
1920 NE Stucki Ave # 150 Hillsboro OR 97006
PHONE: 503-227-3179
FAX: 503-227-3157
EMAIL: inquiry@mvisionlab.com

PRIMARY PATIENT

LAST NAME	FIRST NAME		
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ◯ Male ◯ Female		
ADDRESS	ETHNICITY		
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE	EMAIL (Required)		

Cheek Swab Kits available by USPS priority shipping for $30 within the US (fee waived for orders of $300 or more)

☐ Send kit to address above ☐ Send kit to alternate address

ORDERING PROVIDER

INSTITUTION/PRACTICE NAME	INSTITUTION FAX/EMAIL
PROVIDER LAST NAME	PROVIDER FIRST NAME
NPI (USA) / MINC (CANADA)	EMAIL
PROVIDER PHONE	DELIVER REPORT TO
COLLECTION DATE (MM/DD/YYYY)	Sample type:
MRN / Patient ID	GENETIC COUNSELOR

MEDICAL HISTORY

Fill out medical history or attach documentation

BILLING

Self- Pay (email address required) ◯ MVL staff will email you to setup payment

Institutional Billing ◯

ICD-10 DIAGNOSIS CODE

REFERRAL/PRIOR AUTH

For Institutional Billing Only

HOSPITAL / LAB NAME	CONTACT NAME	EMAIL (required)
PHONE NUMBER	PO# / DEPT CODE (IF USED)	ADDRESS (IF DIFFERENT)

TEST REQUESTED

	OTHER
PRICE	

Self-pay: The full amount of the test fee is due prior to service being rendered. International orders must be made in USD.

If required, we can work together to schedule a payment plan for you.

I attest that the patient has received and read the MVL Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any MVL Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

PATIENT SIGNATURE X	DATE (MM/DD/YYYY)	PROVIDER SIGNATURE X	DATE (MM/DD/YYYY)

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SECOND PAGE OPTIONAL

PATIENT BILLING INFORMATION	MVL staff will email patient for billing if this section is left blank		
NAME ON CARD	CARD NUMBER	EXPIRATION	CVV
PAYMENT AMOUNT			