PLACE PROVIDED BARCODE LABEL HERE

Test Requisition Form

833-258-7827 / customersuccess@clearnotehealth.com

Please complete all required fields (designated by a blue box), and include this form with the sample shipment.

CLIA LAB ID: 05D2249973

PATIENT INFORMATION

First Name, MI ______

Last Name ______

MRN/Other Patient ID ______

Date of Birth ______ Ethnicity ______

Sex at Birth ______

Street Address ______

City/State/Zip ______

Email ______

Phone Number ______

PROVIDER INFORMATION

Name ______

Institution/Account Name ______

Email ______

Phone Number ______

Secure Fax Number ______

Additional Report Recipient (optional) ______

Email ______

Phone Number ______

Secure Fax Number ______

CLINICAL INFORMATION

Ordering clinicians should report diagnosis codes based on documentation in the patient's medical record.

ICD-10 Code(s): ______

Date of Type 2 Diabetes Diagnosis: ______

Body Mass Index (BMI): ______

Check all that apply:

- ☐ Family History of Pancreatic Cancer
- ☐ Chronic Pancreatitis
- ☐ Intraductal Papillary Mucinous Neoplasm (IPMN)
- ☐ Heavy Smoker (>20 packs per year) ◯ Current ◯ Former
- ☐ Known Genetic Risk Factors (please list gene and the variant below)
  - ◯ If known: ______

Other Clinical Information: ______

PATIENT INSURANCE / BILLING INFORMATION

Bill this Account:

☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ Patient (Self-Pay) ☐ Other

Policyholder Name ______

Policyholder Date of Birth ______

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other

Primary Insurance Provider ______

ID Number ______

Group Number ______

Secondary Insurance Provider ______

ID Number ______

Group Number ______

SAMPLE INFORMATION

Date Collected (mm/dd/yyyy) ______ Time Collected (hh:mm am/pm) ______ Number of Whole Blood Tube/s Collected (Streck tubes only) ______

Hospital Status at the time of Collection:

☐ Inpatient (Discharge Date mm/dd/yyyy) ______ ☐ Outpatient ☐ Doctor's Office ☐ Laboratory/Phlebotomy

ORDERING PHYSICIAN AUTHORIZATION & ACKNOWLEDGEMENT

Your signature constitutes a Statement of Medical Necessity (SOMN) at your attestation of the following: (1) accurate clinical information has been entered above (2) the patient meets the test criteria (3) the test is medically necessary (4) the patient has consented for this test to be performed and for ClearNote Health to release test information for treatment, care coordination, and/or when necessary to obtain reimbursement or payment and (5) physician or physician delegate has obtained all requisite authorizations from the patient necessary to authorize the release of any medical and insurance information to process claims for services provided by ClearNote Health and is authorized to pursue all necessary appeals of full or partial payment on behalf of the patient with his or her health insurance company in relation to services provided by ClearNote Health. The patient is aware that they are responsible for applicable copayments, deductibles and co-insurance as required by their medical and/or other healthcare benefits plans.

➡ Signature of Authorized Provider ______ Signature Date (mm/dd/yyyy) ______

NOTICE OF USE AND DISCLOSURE OF SAMPLES & INFORMATION

ClearNote Health de-identifies and uses samples for clinical testing and scientific and technical development. If the individual does not wish ClearNote Health to use the sample for these uses, a written request can be sent to ClearNote Health.

Patient Consent for Future Research:
I am interested in participating in research studies conducted by ClearNote Health. I consent to ClearNote Health contacting me for future research. I understand that initialing does not obligate me to participate.

Initials ______

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