

Avantect Pancreatic Cancer Test Requisition Form

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

PLACE PROVIDED BARCODE HERE

CAP ID: 9219174

			CLIA LAB ID: 05D2249973
PATIENT INFORMATION		PATIENT INSURA	NCE / BILLING INFORMATION
First Name			Private Insurance Medicaid Medicare
Last Name			Patient (Self-Pay) Client Other
MRN/Other Patient ID		Policyholder Name (First)	
Date of Birth (mm/dd/yyyy) Sex at Birth		Policyholder Name (Last)	
Ethnicity (please indicate): Hispanic or Latino American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Race/Ethnicity Unknown		Policyholder Date of Birth (mm/dd/yyyy)	
		Relationship to Patient: Self Spouse Other	
		Primary Insurance Provider	
Street Address		ID Number	Group Number
City/State		Secondary Insurance Policy Holder Name (First)	
Country/Zip		Secondary Insurance Policy Holder Name (Last)	
Email		Secondary Insurance Provider	
Phone Number		ID Number	Group Number
PROVIDER INFORMATION			
First Name		Secure Fax Number	
Last Name			
		Email	
Email		Phone Number	
Phone Number ORDERING PHYSICIAN AUTHORIZATION & ACKNOWLEDGEMENT		Secure Lay Mailliner	
Your signature constitutes a Statement of Medical N necessary (3) the patient has consented for this test release of any medical and insurance information to on behalf of the patient with his or her health insuran	ecessity (SOMN) at your attestation of the to be performed and the physician dele- process claims for services provided by nice company in relation to services prov	gate has obtained all requisite ClearNote Health and is autho ided by ClearNote Health. The	al information has been entered above (2) the test is medically authorizations from the patient necessary to authorize the rized to pursue all necessary appeals of full or partial payment patient is aware that they are responsible for applicable copaydagree to the Data Protection Addendum incorporated herein
Signature of Authorized Provider Date (mm/dd/yy		Date (mm/dd/yyyy)	
CLINICAL INFORMATION			
Ordering clinicians should report diagnosis	High Risk of Pancreatic C	ancor	Increased Risk of Pancreatic Cancer
codes based on documentation in the	(check all that apply) New-Onset Diabetes (Diagnosis within the last 3 years) Diabetes (Date of diabetes diagnosis)		(check all that apply)
patient's medical record. ICD-10 Code(s):			Long-standing Diabetes (Diagnosis more than 3 years ago)
	Familial Pancreatic Cancer (2 or more first degree relatives)		Diabetes (Date of diabetes diagnosis)
	Number of 1st degree relatives with pancreatic cancer		Family History of Pancreatic Cancer (1 first degree relative or any 2nd degree relatives)
	Hereditary Breast-Ovarian Cancer (BRCA1, BRCA2)		☐ Smoking (>20 packs per year) Former Current
	☐ Breast and Pancreatic Cancer Susceptibility (PALB2)		Body Mass Index (BMI) greater than or equal to 30; BMI value
	☐ Lynch Syndrome (MLH1, MLH2, MSH6, PMS2, EPCAM) ☐ Peutz-Jeghers Syndrome (STK11/LKB1)		Bill value
Other Clinical Information:	Familial atypical multiple mole melanoma – FAMMM		
(CDKN2A /p16INK4a)		nsis (APC)	
	Ataxia Telangiectasia (ATM)	(5)	



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 Collect	tion (check the hay helaw):	
☐ Inpatient (Discharge Date mm/dd/yyy		ice Laboratory/Phlebotomy
Contraindications		
Pancreatic Cysts including Mucinous	s Cystic Neoplasm (MCN) and Intraductal Papillary N	Aucinous Neoplasm (IPMN); Acute or Chronic Pancreatitis;
Current Active Cancer Diagnosis		
activities including for quality control and an result in commercial products or compensal and clinical testing will be performed wheth and data will not be used for scientific resea de-identified samples or data for these purp	t to keep, use, and disclose your de-identified samples and da halysis, test validation, assay development and improvement, s tion of any sort, proceeds will not be shared with you or your ' er you provide consent. If you do not check the box and sign b arch, test development, or other secondary activities. If you sign boses, you can send a written revocation of consent to ClearN	ata indefinitely for ongoing scientific research, technical development, and other scientific research, publication or presentation, and market research. If these activities family, even if your de-identified sample(s) or data are used. This consent is optional below, ClearNote Health will interpret this as "Opt-Out" and your de-identified samples on below and later decide that you no longer want ClearNote Health to use your ote Health at the address below. Any such revocation will not have any effect on the
By checking this box and signing below,	I acknowledge that I have read the consent to additional use:	(ii) any use or sharing of samples or data that has already occurred. s of samples and data above and consent to ClearNote Health's retention, use, and otection Addendum incorporated herein by reference https://www.avantect.com/
Patient Signature	Date (mr	n/dd/yyyy)

