revivegenetics.us

Revive Genetics Diagnostics Laboratory

CLIA: 10D2337214

Pharmacogenomics (PGX)

Requisition & Consent Form

Patient Information

Last Name	First Name	DOB	Sex	MRN

Address	City	State	Zip	Phone Number

Email

Ethnicity ☐ African American ☐ Ashkenazi Jewish ☐ East Asian ☐ Hispanic ☐ Middle Eastern ☐ White ☐ Other

Insurance/Billing Information

Insurance Name	Member ID	Group ID

Primary Name	Primary DOB	Relationship
		☐ Self ☐ Spouse ☐ Child

Ordering Provider/ Facility

Provider Name	NPI	Facility Name	Email

Address	City	State	Zip	Phone Number

Specimen Information

Specimen Type

Collector Name	Collection Date/ Time	Collection Site
		☐ Office ☐ Lab ☐ Home ☐ Other

Confirmation of Informed Consent and Medical Necessity for Genetic Testing

My signature below certifies that I am a licensed medical professional or his/her representative or a genetic counselor authorized to order genetic testing. My signature further acknowledges the patient has been supplied information regarding genetic testing and has been informed about the purpose, limitations, and possible risks. The patient has been given the opportunity to ask questions about this consent and seek outside genetic counseling. The patient has given consent for genetic testing to be performed and the signed consent form is on file. I confirm that this testing is medically necessary for the specified patient, and that these results will be used in the medical management and treatment decisions for this patient. I confirm that the patient has been informed and hereby authorizes (i) **Revive Genetics Laboratory** to release information concerning their testing to their insurer to obtain reimbursement for the testing services; (ii) **Revive Genetics Laboratory** to be paid directly by the insurer for services rendered; and/or, if applicable, (iii) **Revive Genetics Laboratory** or its affiliates to be the patient's designated representative for the purpose of appealing any denial of insurance benefits. I confirm the patient fully understands they are legally responsible for sending **Revive Genetics Laboratory** all money they receive directly from their insurance company as payment for this testing.

Medical Professional Signature: _____ **Date:** _____

Print Name: _____

revivegenetics.us

Revive
Genetics
Diagnostics
Laboratory

CLIA: 10D2337214

Pharmacogenomics (PGX)
Requisition & Consent Form

Test Selection

Select	Panel	Genes	Brief Description
	Express Gene™ Comprehensive Pharmacogenomics (PGX) Panel	38 Genes	This panel is testing Targeted SNPs in 38 genes related to drug-response, metabolism, potential risks, dosage, and patient therapeutic plan management.
	Express Gene™ Cardiovascular-Focused Pharmacogenomics (PGX) Panel		This panel tests targeted SNPs in genes associated with cardiovascular medication response, metabolism, dosing considerations, and potential adverse reactions. It is designed to support personalized therapeutic decision-making for medications commonly used in cardiology, including anticoagulants, antiplatelet agents, statins, beta blockers, and antihypertensive therapies.
	Express Gene™ Neuropsychiatric Disorder-Focused Pharmacogenomics (PGX) Panel		This panel tests targeted SNPs in genes associated with psychiatric medication response, metabolism, tolerability, and dose optimization. It supports individualized treatment planning for antidepressants, antipsychotics, mood stabilizers, anxiolytics, and other neuropsychiatric therapies by identifying genetic factors that may influence therapeutic outcomes and side effect risk.
	Express Gene™ Pain Management- Focused Pharmacogenomics (PGX) Panel		This panel tests targeted SNPs in genes associated with pain medication response, metabolism, efficacy, and risk of adverse effects. It is intended to guide personalized pain management strategies for opioids, non-opioid analgesics, and adjunct therapies by evaluating genetic factors that may influence drug effectiveness, sensitivity, and safety.
	Express Gene™ Cancer Medication- Focused Pharmacogenomics (PGX) Panel		This panel tests targeted SNPs in genes associated with cancer medication response, metabolism, toxicity risk, and dosage considerations. It is designed to support precision treatment planning for oncology therapies by identifying genetic variants that may affect drug efficacy, tolerability, and individualized medication selection.

Indications for Testing (Check All That Apply)

☐ Diagnostics ☐ Family History ☐ Adverse Drug Reaction ☐ Patient Management ☐ Drug Interactions

Clinical Information

Genetic Testing Done Previously: ☐ Yes ☐ No	If Yes what test:	Date of Previous Test: ____/____/____

Revive Genetics Diagnostics Laboratory

CLIA: 10D2337214

Pharmacogenomics (PGX)
Requisition & Consent Form

List relevant family history of disease (affected family members and relationship to patient):

List of all current medications ***(Important):***

Informed Consent

Consent to Testing and Use of Results

The specimen identified on this form is my own or from my minor child. I have not contaminated it in any way. I am voluntarily submitting this specimen for analysis by my physician and/or **Revive Genetics Laboratory**. I authorize **Revive Genetics Laboratory** to release the test results to the ordering healthcare provider. I further authorize the laboratory and my healthcare provider to release to my insurance carrier any medical information necessary to process the claim.

Consent for Genetic Testing

Your healthcare provider has ordered a genetic test for you or your minor child. This test analyzes genetic variations that may affect overall health, disease risk, or response to treatment. If genetic variant(s) are identified, they may indicate an increased risk of developing certain inherited conditions or determine whether you are a carrier of a hereditary disease.

A negative result does not completely rule out the possibility of disease, as some disease-causing genetic variants remain unknown or have not yet been fully characterized. Additionally, next-generation sequencing and other genetic testing methodologies have technical limitations, and certain types of genetic variants may not be detected by the testing method used.

All test results are treated as confidential and are released only to the patient, the ordering healthcare provider, and other individuals authorized by the patient or required by law. No tests other than those authorized will be performed. Patient specimens will be retained for up to **60 days** following completion of testing and then destroyed according to laboratory policy unless otherwise required.

I have read this consent form, or it has been read to me. I have received a copy of this form. I have been given the opportunity to ask questions before signing this consent, and I understand that I may ask additional questions at any time. I voluntarily consent to the requested genetic testing.

Consent / Insurance Release

By signing this form, I authorize **Revive Genetics Laboratory** to submit medical information related to this testing to my designated insurance carrier for reimbursement when necessary. I authorize payment of benefits directly to **Revive Genetics Laboratory**. I understand that I am responsible for any amounts not covered by my insurance, including but not limited to non-covered, non-authorized, or denied services. I authorize a copy of this authorization to be used in place of the original.

Patient or Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____

Optional Consent for Research and Future Contact

To improve genetic testing and advance the understanding of inherited genetic disorders, I voluntarily authorize **Revive Genetics Laboratory** to use any remaining specimen, de-identified genetic data, and/or clinical information for research, educational, quality improvement, or laboratory development purposes. My identity will not be disclosed in any publication or research activity.

I also authorize **Revive Genetics Laboratory** to contact me in the future regarding newly discovered disease-associated genes, updated variant classifications, research opportunities, or clinically relevant follow-up related to my testing.

Participation is voluntary. Choosing not to participate will not affect the performance of my ordered test or my medical care.

Patient or Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____

Medical Professional Signature: _____ **Date:** _____

Print Name: _____

Website www.revivegenetics.us **Email** info@revivegenetics.us	**Address** 9000 SW 152nd St Suite 107, Palmetto Bay, FL 33157	**Lab Director** Uzma Farooq, MD	**Phone Number** 786-250-3419