

PancreasDx Test Requisition Form

The 12-gene panel represents next-generation sequencing and deletion/duplication analysis of *PRSS1-2*, *PRSS3*, *CFTR*, *SPINK1*, *CASR*, *CTRC*, *CEL*, *UBR1*, *SDBS*, *CPA1*, and *GGT* and sequencing of two regions of interest near *CLDN2* and a region within *SLC26A9*.

Please select if you would like the following panel to be included in the PancreasDx analysis:

- ArielDx Lipids:** A targeted 6-gene panel for variants associated with abnormal lipid metabolism that may increase risk of pancreatitis. Genes include: *PPARG*, *LPL*, *APOA5*, *APOB*, *FABP4*, and *APOC2*.

Patient Information

This information is used to register the patient's sample collection kit. Please ensure that this information is precise and up to date. An email address **must** be provided for each patient.

Name: _____ DOB: MM / DD / YYYY
 Email: _____ Phone: () _____

1 Indications for Testing

Select the option that best characterizes the primary etiology. This is needed to understand the patient's condition and is required for billing. These descriptors are tied to ICD-10 codes.

Acute Pancreatitis	w/ necrosis or infection			Chronic Pancreatitis
	w/ necrosis or infection	w/ uninfected necrosis	w/ infected necrosis	
Alcohol-Induced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol-Induced <input type="checkbox"/>
Biliary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cystic <input type="checkbox"/>
Drug-Induced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interstitial <input type="checkbox"/>
Idiopathic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent <input type="checkbox"/>
Unspecified Acute Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Relapsing <input type="checkbox"/>
Other Acute Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Chronic Pancreatitis <input type="checkbox"/>

Year of initial Acute Pancreatitis attack: _____
 Check here if recurrent
 If recurrent, frequency of attacks: _____

Year of diagnosis: _____
 Method of diagnosis: _____

2 Family History

No known family history Unknown / Adopted

Provide information on relevant family history, especially on pancreatitis (specify chronic or acute, if known), pancreatic cancer, cystic fibrosis or CF-related disorders, or diabetes. Please include relationship to patient and maternal vs. paternal status.

3 Prior Genetic Testing

No prior testing
 Prior genes tested: _____

Attach copies of all genetic testing results.
 For results, format as:
 (Gene | c.XXXX | p.XXXX | Pathogenic vs VUS)

4 TIGAR-0 Classification (check all that apply):

Toxic/Metabolic	Idiopathic	Genetic	Auto-Immune	Rec. Acute / Severe	Obstructive
<input type="checkbox"/> Alcohol related <input type="checkbox"/> Smoking related <input type="checkbox"/> Hypercalcemic <input type="checkbox"/> Hypertriglyceridemia <input type="checkbox"/> Drug Induced (Specify):	<input type="checkbox"/> Early Onset (<35 years of age) <input type="checkbox"/> Late Onset (>35 years of age)	<input type="checkbox"/> Hereditary pancreatitis <input type="checkbox"/> Cystic Fibrosis / CFTR-Related Disorder <input type="checkbox"/> Familial Pancreatitis Syndrome (<i>SDBS</i> , <i>UBR1</i>)	<input type="checkbox"/> Isolated <input type="checkbox"/> IgG4-related	<input type="checkbox"/> Recurrent Acute <input type="checkbox"/> Severe acute with necrosis	<input type="checkbox"/> Biliary <input type="checkbox"/> Pancreas Divisum <input type="checkbox"/> Sphincter of Oddi Dysfunction <input type="checkbox"/> Post Traumatic <input type="checkbox"/> Post Surgical

5 Indications for Testing (cont.)

Please check all that apply.

Diabetes	w/ complications	w/o complications	Cystic Fibrosis/CFTR Disorder	
Type 1	<input type="checkbox"/>	<input type="checkbox"/>	CF w/ Acute Pneumothorax	<input type="checkbox"/>
Type 2	<input type="checkbox"/>	<input type="checkbox"/>	CF w/ Hemoptysis	<input type="checkbox"/>
Type 3c (Pancreatogenic)	<input type="checkbox"/>	<input type="checkbox"/>	CF w/ Meconium Ileus	<input type="checkbox"/>
Mature Onset Diabetes of the Young	<input type="checkbox"/>	<input type="checkbox"/>	CF w/ Pneumothorax Not Otherwise Specified	<input type="checkbox"/>
Hyperglycemia	<input type="checkbox"/>	<input type="checkbox"/>	CF w/ Pulmonary Manifestations	<input type="checkbox"/>
Pancreatic Exocrine Insufficiency			CF Unspecified	<input type="checkbox"/>
Pancreatic Exocrine Insufficiency	<input type="checkbox"/>		CF w/ Other Intestinal Manifestations	<input type="checkbox"/>
Chronic Diarrhea	<input type="checkbox"/>		CF, Screen Positive, Inconclusive Diagnosis	<input type="checkbox"/>
Magnesium Deficiency	<input type="checkbox"/>		CFTR-related Acquired Chronic Bronchiectasis	<input type="checkbox"/>
Malabsorption	<input type="checkbox"/>		CFTR-related CBAVD	<input type="checkbox"/>
Steatorrhea	<input type="checkbox"/>		CFTR-related Recurrent Pancreatitis	<input type="checkbox"/>
Vitamin Deficiency	<input type="checkbox"/>		CRMS Metabolic Disorder Unspecified	<input type="checkbox"/>
Zinc Deficiency	<input type="checkbox"/>			

6 Additional Clinical Data

Please attach or detail below any additional clinical information that supports this patient's analysis, such as any complications of current conditions, surgical or endoscopic history, or previous treatments.

7 Current Medications

Please detail the drug, route of admission, and dose of each currently prescribed medication.

8 Genetic Counseling Opt-Out

Ariel Precision Medicine offers pre-test genetic counseling to our patients. Genetic counseling is **strongly** recommended. All Ariel patients will be provided this service. By checking this box, you are choosing to opt-out of genetic counseling services provided by Ariel Precision Medicine.

Initials: _____

Referring Physician

Physician Name (print): _____

Phone: (_____) _____

Address: _____

Fax: (_____) _____

Address (cont'd): _____

Email: _____

Institution: _____

Genetic Counselor/Lab Contact Name: _____

Phone: (_____) _____

Email: _____

Fax: (_____) _____

Medical Necessity & Signature

By checking this box, I affirm the undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirm the patient has given appropriate consent. I confirm that testing is medically necessary and that test results may impact medical management for the patient. Furthermore, all information on this order form is true to the best of my knowledge.

I have attached a Letter of Medical Necessity (LMN) and/or other documentation for insurance billing purposes.

I agree to allow Ariel Precision Medicine to transfer this information, and any attached information, from this requisition for a LMN using the ordering physician's name as the signature for insurance billing.

Name: _____ Signature: _____ Date: _____

Title: _____ Degree: _____ NPI #: _____

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