Swab DNA Test Request Form

Patient Information

Full Name: _________________________

Date of Birth: _________________________

Gender: _________________________

Contact Information

Address: ____

Phone: _________________________

Email: _________________________

Ordering Physician Information

Full Name: _________________________

Medical License Number: _________________________

Contact Information

Phone: _________________________

Email: _________________________

Clinical Information

Reason for DNA Testing:

____

Relevant Medical History:

____

Family History of Genetic Conditions:

____

Test Details:

Type of Test Requested:

- [ ] Ancestry
- [ ] Health Risk

- ☐ Pharmacogenetic
- ☐ Other (Specify): ____

Preferred DNA Collection Method:

- ☐ Cheek Swab
- ☐ Buccal Swab
- ☐ Other (Specify): ____

Additional Testing Requested (if any):

____

Special Instructions

Patient Preparation Instructions:

Any Specific Precautions or Considerations:

Preferred Date/Time for Sample Collection: _______________________

Billing Information

Insurance Information:

____

Authorization/Referral Number (if applicable): _______________________

Billing Contact Information: _______________________

Acknowledgment and Consent

I, the undersigned, acknowledge that I have been informed about the DNA test's purpose, potential risks, and benefits. I consent to collecting and analyzing my DNA sample for the specified testing purposes. The results will be shared with the healthcare provider, and additional genetic counseling may be recommended based on the findings.

Patient Signature: John A. Doe

Date: _______________________