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: _____

Date: _____