



CT License CL-0644
CLIA ID # 07D1036625

LABORATORY OF PERSONALIZED HEALTH
Division of Genomas Inc.
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Tel (860) 545.4589 Fax (860) 545.4598
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HILOmet TESTS REQUISITION FORM

Patient name _____	Patient ID _____
Patient date of birth _____	Patient age _____

Patient gender

Male Female

Patient ethnicity

Caucasian Asian African American Hispanic

Name of Physician/Clinician requesting test(s) _____

Address and email of physician or healthcare provider requesting test(s)

Street _____ Telephone (____) _____ - _____

City _____ State _____ Zip Code _____ FAX (____) _____ - _____

Please select the tests to be performed:

<input type="checkbox"/> HILOmet 2C9 (CYP 2C9) (CLP Test Code: 70000)	<input type="checkbox"/> HILOmet 2C19 (CYP 2C19) (CLP Test Code: 70001)	<input type="checkbox"/> HILOmet 2D6 (CYP 2D6) (CLP Test Code: 70002)
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For Warfarin (Coumadin®), check the box below and provide AGE, WEIGHT, HEIGHT:

HILOmet WARFARIN (CYP 2C9 + VKORC1)
(CLP Test Code: 70004) AGE _____ WEIGHT _____ lbs. HEIGHT _____ ft. in.

For Clopidogrel (Plavix®), check the box below:

HILOmet 2C19 (CYP 2C19) (CLP Test Code: 70001)

For Tamoxifen (Nolvadex®), check the box below:

HILOmet 2D6 (CYP 2D6) (CLP Test Code: 70002)

Current Medication(s) _____

Intended Medication(s) _____

Comments _____

Signature _____ Date _____

Instructions to Phlebotomist: (1) Sample collection Date _____ and Time _____ (2) Send 1 cc fresh whole blood collected in an EDTA vacutainer tube (3 cc size, purple top). The minimum sample volume required is 0.5 cc. *One tube is adequate regardless of number of tests.* (3) The tube should be labeled with patient's first and last name or unique identifier; patient's date of birth, or sex and age; date and time of collection. (4) The tube with blood should be enclosed in a sealed bag for biohazardous materials and sent in an appropriate container to the address above for same day delivery. Tubes held overnight should be kept at 4°C. (5) **This requisition form should accompany the sample.**