CLIA # 11D2154238
6270 McDonough Drive, Suite G
Norcross, GA 30093
Phone: (770) 988-6951
www.nextgenomixlab.com

# Epidermal Nerve Fiber Density Test Requisition

## Patient Information(attach a copy of patient demographic sheet)

Name (Last name, first)

DOB (mm/dd/yyyy) Age Gender ☐ Male ☐ Femal

Address

City/State Zip Code

Phone Email

## Ordering Physician Information (required)

Facility Name

Name (Last name, first) Medical Credentials NPI #

Address

City/State Zip Code

Name of Office Contact Telephone

## Patient Payment Options

☐ **Insurance:** Please

☐ **Self-Pay:** Next Genomix Laboratories will contact patient to obtain payment. **Client**

☐ **Bill or Institution Bill**

## Patient Insurance (attach a copy of front and back of insurance card)

Primary Insurance ID/Subscriber/Polcy #

Group # Phone

Insured Name Employer/Phone

## Clinical Information (check all that apply)

☐ Yes ☐ No Needle electromyography (EMG) and nerve conduction velocity studies do not, in your clinical experience, completely rule out and large-fiber neuropathy

☐ Yes ☐ No Physical examination shows no evidence of findings consistent with large-fiber neuropathy

☐ Yes ☐ No Individual presents with painful sensory neuropathy

## Diagnosis ICD-10 Codes

☐ G60.3 Idiopathic progressive neuropathy

☐ M79.2 Neuralgia and neuritis, unspecified

## Other Diagnosis/History (include all applicable ICD-10 codes)

## Specimen Information

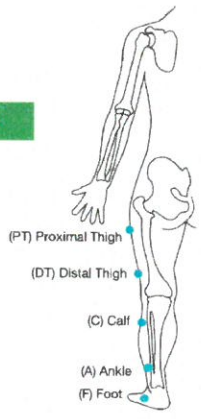
Collection Date/Time

## Standard Biopsy Locations (Depth: minimum 3mm)

**Proximal Thigh (PT)** - 10 cm below greater trochanter (hip joint)
**Distal Thigh (DT)** - 10 cm above the lateral joint line of knee
**Calf (C)** - 15 cm below the lateral joint of the knee
**Ankle (A)** - 5 cm to 10 cm above the lateral malleolus (ankle)
**Foot (F)** - Dorsum of the foot, in the extensor digitorum brevis muscle belly
Other Site (OS) Other Site (OS)

## Indicate the biopsy location(s) below and label the vial(s) with the corresponding site and patient's name and DOB

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Sample **A** | ☐ LEFT | ☐ RIGHT | ☐ Prox Thigh | ☐ Distal Thigh | ☐ Calf | ☐ Ankle | ☐ Foot | ☐ Other Site |
| Sample **B** | ☐ LEFT | ☐ RIGHT | ☐ Prox Thigh | ☐ Distal Thigh | ☐ Calf | ☐ Ankle | ☐ Foot | ☐ Other Site |
| Sample **C** | ☐ LEFT | ☐ RIGHT | ☐ Prox Thigh | ☐ Distal Thigh | ☐ Calf | ☐ Ankle | ☐ Foot | ☐ Other Site |
| Sample **D** | ☐ LEFT | ☐ RIGHT | ☐ Prox Thigh | ☐ Distal Thigh | ☐ Calf | ☐ Ankle | ☐ Foot | ☐ Other Site |




## Patient Informed Consent (please sign here)

Authorization to release information and pay benefits: I confirm that I have been informed about the details of the tests ordered for me by my provider that includes NextGenomix Laboratories ENFD Test. I give permission to NextGenomix Laboratories to perform the test as prescribed. I do hereby name NextGenomix Laboratories located at 6270 McDonough Drive, Suite G, Norcross, GA. 30093 to act as my Authorized Representative in requesting a prior authorization, appeal or documents from my health insurance carrier regarding the above-noted service or proposed service and to inform my health plan of my test result only if required for preauthorization or payment of additional reflex testing. I understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance. By signing below, I authorize that payment(s) be made on my behalf to NextGenomix Laboratories for any services provided to me by NextGenomix Laboratories. I also authorize the release of any medical information necessary to process this claim

**Patient Signature** **Date**

## Confirmation of Informed Consent and Medical Necessity

Authorization for NextGenomix Laboratories: The tests ordered are medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine this patient's medical management and treatment decision as indicated in the medical necessity document provided on the reverse side of this form. The person listed as the Ordering Physician is legally authorized to order the test(s) requested here in. The patient was provided with information about the risks and benefits of genetic testing and has consented to genetic testing. Medical necessity is provided on the back of this form.

**Ordering Physician Signature** **Date**

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# Epidermal Nerve Fiber Density Test Requisition

## Shipping and Specimen Requirements

**Shipping Address:**
Attn: NextGenomix Laboratories
6270 McDonough Drive, Suite G, Norcross, GA 30093.

**Specimen Requirements:** Collect specimens using the punch biopsy tray kit provided and place each biopsy into the labeled transport media (Zamboni Fixative). Follow the collection instructions provided very carefully.

**Labeling Requirements:** Label sample tubes with at least two identifiers and biopsy site (e.g. proximal thigh). Patient's full name and date of birth, preferred. We strongly recommend including the medical record number and/or specimen ID number.

**Packaging and Shipping requirements**: The biohazard bag should contain biopsy specimens in labeled Zamboni tubes. Completed Requisition Form with patient demographic sheet and insurance information should be placed in outside pocket of biohazard bag. Place the frozen gel pack into insulated sleeve provided with kit and place the biohazard bag on top of the frozen gel pack. Place the insulated sleeve into UPS laboratory Pak affixed with the pre-printed UPS return label. Biopsy should be shipped the same day the biopsy is performed.

**Result Delivery:** Results are typically delivered within 7 business days. If urgent, clinically actionable results are obtained, they will be communicated by phone, followed by electronic notification. If clarification of the test order or an additional specimen are needed, the client will be contacted. Please provide phone and email for communication (page 1).