Boston Heart Test Add-On Form

Please fill out the requested information below.

Client ID #: _____

Patient Name:_____Patient DOB:_____ /_____ /_____

Boston Heart Diagnostics Accession #:_____Collection Date:_____ /_____ /_____

Name of Requested Tests (please provide test or panel # whenever possible)

ICD-10 Codes				

All reasonable attempts will be made to add the requested tests. Testing will be not be run if the samples received in the lab were an incorrect sample type, insufficient quantity, or past standard laboratory retention time or stability at the time of the add-on request.

Please contact Customer Care with any questions at 877.425.1252. Fax completed forms to 508.663.5484.

Medical Professional Statement

By submission of this requisition, I: (i) authorize and direct you to perform the testing indicated above; (ii) certify that any custom profile on file and/or the ordered tests requested on this test requisition form are reasonable and medically necessary for the diagnosis and/or treatment of this patient's condition on this date of service, (iii) certify that, to the extent required by the laws of the state in which I am licensed and provide healthcare services, I have obtained this patient's written informed consent to undergo any genetic testing requested hereby, and to have the test results reported to me; (iv) agree to provide you with a copy of this patient's signed and dated consent form upon your request; (v) am aware that genetic testing should only be performed once in a patient's lifetime and (vi) that the full and appropriate diagnosis code(s) are indicated to the highest level of specificity.

Printed Name of Ordering Provider:_____

Signature of Ordering Provider:_____Date:_____ /_____ /_____

Results will not be reported for this sample until this document has been completed and returned to the laboratory.

TO BE COMPLETED BY BOSTON HEART DIAGNOSTICS:

☐ Completed_____ Date:_____ /_____ /_____ ☐ Not Completed_____ Date:_____ /_____ /_____

Notes: