Machaon Diagnostics

National Service with Labs in California and Louisiana
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ADAMTS13 Test Order Form

TAT <24 hours, 7 days a week; order STAT for weekend testing

MachaonDiagnostics.com
1-800-566-3462

PATIENT INFORMATION (*complete or attach*)

Patient's Name: (Last, First, M.I.) *required*	Sex: *required* ○ M ○ F
Specimen Date and Time: *required*	DOB: (MM/DD/YYYY) *required*
MRN: *required*	Accession #:

SUBMITTING FACILITY

Facility Name and Address: *required*

Facility Phone Number: *required*

Fax Number for Results: *required*

ORDERING PHYSICIAN INFORMATION

Physician's Name: (Last, First, M.I.) *required*

Physician's direct phone number to call results: (*called within 24 hours*)

Fax Number for Results:

BILLING INFORMATION

Bill to: ☐ **Facility** ☐ **Insurance** ☐ **Patient** ☐ **Medicare**

Patient status: ☐ **Inpatient** ☐ **Outpatient**

☐ **STAT** *Samples shipped for weekend analysis must be ordered STAT. Mark FedEx Airbill for 'SATURDAY Delivery.'*

CLINICAL INFORMATION (*if available*)

Last Plasma Infusion Date: (MM/DD/YY)		LDH: (U/L)
Creatinine: (mg/dL)	PLT Count: (K/µL)	Hemoglobin: (g/dL)

Clinical Suspicion:
☐ TMA ☐ TTP ☐ HUS ☐ Shiga toxin-related HUS ☐ aHUS ☐ Other
(Call lab with ADAMTS13 Gene Sequencing requests)

TEST SELECTION

☐ ADAMTS13 Activity reflex Inhibitor	*Reflexes to Antibody*
☐ ADAMTS13 Activity, Inhibitor and Antibody	
☐ Reflex to aHUS Genetic Panel when ADAMTS13 Activity is >5% (3mL EDTA whole blood sample required)	

Informed Consent for Genetic Testing (required for patients drawn in New York state)

Providers are required to obtain informed consent from patients for genetic testing for all genetic samples originating in New York. An informed consent form may be found at machaondiagnostics.com, with a description of the test, purpose, and limitations. In lieu of submitting a copy of the signed informed consent, healthcare providers may sign the below statement attesting that informed consent has been obtained.
Verification of Informed Consent: I am a healthcare provider for the patient named on this requisition. I have obtained the required informed consent from the patient or the patient's legal guardian for each genetic test ordered on this requisition and I authorize testing of the provided specimen.

Signature of Physician: _____ Date: _____

Note: testing may be delayed if a consent form is not received or the provider signature is not present.

OUTPATIENT ONLY: INSURANCE BILLING INFORMATION (*complete or attach*)

Insurance Company: (*Medicare patients must sign ABN*)		
Insurance Policy / Medicare Number:	Insurance Group Number:	
Insurance Company Address:	Authorization Number:	
Insurance Company City:	State:	Zip Code:

Patient Address:	Patient Phone Number:
Patient City:	State: Zip Code:

DIAGNOSIS CODE(S):

ICD-10 Code:	ICD-10 Code:	ICD-10 Code:

OUTPATIENT ONLY: PATIENT SIGNATURE

Machaon Diagnostics may need to obtain additional information from your physician to complete these services. I hereby authorize the release of medical information related to the services described herein and authorize payment directly to Machaon Diagnostics. Machaon Diagnostics is a PARTICIPATING PROVIDER of Medicare only. The activity test is $248 and reflexes to the inhibitor ($530) and antibody test ($250); shipping charges may apply. I agree to assume responsibility for payment of all charges not covered by my healthcare insurer.

Patient's Signature:
X:_____ Date:_____

ADDITIONAL INFORMATION

Machaon Diagnostics is a specialized coagulation and platelet laboratory that provides comprehensive clinical evaluations of bleeding and clotting patients. Most evaluations can be completed within 24 hours, 7 days a week. Machaon Diagnostics is a California-licensed, CLIA-accredited, CAP-accredited, clinical laboratory approved to provide high-complexity testing services. Machaon Diagnostics is a PARTICIPATING PROVIDER of Medicare only. Patients with insurance coverage other than Medicare are considered OUT-OF-NETWORK and will be billed for services not covered by their insurance provider. Medicare patients must sign an ABN, either located on the reverse side of this form or downloaded from the Machaon Diagnostics website. Patient insurance billing services are provided in accordance with the Machaon Insurance Billing Policy. HMO or medical group covered patients may need a prior authorization if they seek full reimbursement. For more information please visit MachaonDiagnostics.com or call (510) 839-5600.