Arkana Laboratories

APOL1 Consent and Requisition Form

Affix patient sticker here

Specimen Information: ☐ Blood ☐ FFPE ☐ Frozen block ☐ DNA

Laboratory test values:

☐ Creatinine ☐ Levels not elevated Current:_____ Baseline:_____

☐ Protein ☐ Not present ☐ Macro ☐ Micro

Is patient being tested for living kidney donation? ☐ Yes ☐ No

Patient or family member previously tested for disease? ☐ Yes ☐ No If yes, please describe results and/or attach report.

Reason(s) for testing:

☐ Diagnosis ☐ Family history ☐ Assess risk ☐ Other: _____

Prior renal biopsy evaluated at Arkana? ☐ Yes ☐ No

Patient Information:

Patient Name: _____ Date of Birth (MMDDYYYY): _____ Gender: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Email: _____ Institution: _____ Medical Record #: _____

Is the patient adopted? ☐ Yes ☐ No Has the patient received a bone marrow or kidney transplant? ☐ Yes ☐ No

Race & Ethnicity: check all that apply

☐ Black/African American ☐ Asian ☐ White/Non-Hispanic Caucasian ☐ Ashkenazi Jewish ☐ Other:

☐ Hispanic ☐ American Indian ☐ Native Hawaiian or Pacific Islander ☐ Native Alaskan

Third-Party Billing Information: Complete or attach a copy of insurance card and authorization

Insured/Responsible Party: _____ Date of Birth (MMDDYYYY): _____ Gender: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Member ID #: _____ ☐ Medicare ☐ Medicaid ☐ HMO ☐ PPO ☐ Other

Policy #: _____ Group #: _____

Insurance Co Name: _____ Insurance Co Address: _____ Insurance Co Phone #: _____

Employer Name: _____ Employer Phone #: _____

Referral Authorization/Precertification #: _____

Print Name: _____ Signature: _____ Date: _____

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arkanalabs.com

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Patient Name: _____

Date of Birth (MMDDYYYY): _____

Referring Physician Information:

Name: _____ ☐ MD ☐ DO Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____

Institution: _____ City: _____ State: _____ Zip Code: _____

Patient seen by Genetic Counselor? If yes, please provide contact information. Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Institution: ☐ Same as referring physician ☐ See below

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Specimen and Shipping Information:

Please contact Arkana Laboratories at (501) 604-2695 to request a kit.

Arkana Laboratories Molecular Policies

By requesting testing from Arkana Laboratories Molecular Division (ALMD), the ordering physician indicates that they understand and accept the policies of the ALMD, as listed below, and has communicated these policies to the patient.

A. The laboratory testing performed in ALMD requires advanced technology and is performed by highly skilled doctors and technicians. As in any laboratory, despite our best and diligent efforts there is a small possibility that a test will not work or that an error may occur.

B. Should required information not be provided in the test requisition form, lab personnel may contact patients directly to obtain or verify information required to complete the form.

C. Results will only be released to the ordering physician and other providers listed on the requisition form.

D. It is the responsibility of the ordering physician to disclose test results and direct the patient's care as appropriate.

E. Turnaround times (TAT) for testing represent an estimate of the typical turnaround time for the test, but are not guaranteed.

Ordering Provider Signature

I, _____ (Print Name), as ordering physician, certify that the patient being tested and/or their legal guardian have been informed of the risks, benefits, and limitations of the testing ordered, as well as the policies of ALMD listed above. I have obtained informed consent, as required by my own state and/or federal laws. In addition, I assume responsibility for returning the results of genetic testing to my patient and/or their legal guardian and for ensuring that my patient receives appropriate genetic counseling to understand the implications of their test results.

_____ _____

Signature (Ordering Physician) Date

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NOTE: Please obtain patient/guardian signature on the consent form below. Failure to submit a completed consent may delay initiation of testing.

I, (name)_____, voluntarily request for Arkana Molecular Diagnostic Laboratory to perform the genetic test for APOL1-related nephropathy for myself/my child (child's name _____), in an attempt to determine whether I/my child have a genetic explanation for kidney disease.

The following information was explained and I understand that:

- Additional samples may be needed if the sample is damaged in shipment or inaccurately submitted.
- As with any complex test, there is a small chance of a failure or error in sample analysis. Many measures are taken to avoid these errors. Uncommonly, an additional sample may be needed.
- Due to the complexity and potential implications of DNA testing, results are only directly reported to the ordering provider. Patient results and information are private and confidential, and will only be released to other parties with written consent from the patient.
- The patient can choose whether or not their leftover sample can be de-identified and used for research purposes. If no choice is indicated below it is assumed that the patient opted-out, and the sample will not be used for research purposes.

I consent for the use of my sample for research: ☐ Yes ☐ No

Financial responsibility:

Test cancellation:

If testing is cancelled prior to test set-up, processing will be discontinued and there will be no charge. If a test cancellation is received after set-up, a cancellation report will be generated and a set-up fee will be charged. Test cancellations received after the test assay has been started will be charged a technical fee.

Coverage or noncoverage by insurance:

Some insurance companies do not cover genetic testing as they regard it as unnecessary or experimental. In the event that a patient's healthcare plan does not reimburse Arkana Laboratories for genetic testing, the patient is held responsible for test charges and will be contacted to make arrangements for payment. If your insurance is covered under Medicare please complete the attached advanced Beneficiary Notice of Noncoverage (ABN: form CMS-R-131) on pages 3 and 4, and please select an option for billing. For non-Medicare patients, compassionate use, partial down-payment and/or payment plans can be negotiated by contacting Arkana Laboratories (Toll Free phone number for Billing Manager: 866-269-9819).

Signatures:

Genetic testing may be delayed pending receipt of the following documents; completed test requisition signed by the healthcare provider responsible for the patient's care; this consent document with signatures from the patient/guardian; and a completed ABN if your healthcare costs are covered under Medicare.

Patient/Guardian signature:

I understand the benefits, risks, and limitations of the above requested testing and wish to proceed with it.

Patient/Patient Guardian Print Name	Date	Patient/Patient Guardian Signature	Date

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