Authorization for Pharmacogenetic Testing and Personalized Medication Review

Patient Name: _____ DOB: _____ Date: _____

Address: _____

Phone Number: _____

☐ Patient's current medications regimen could be affected by the patient's genetics

☐ Patient could benefit from preemptive pharmacogenetic testing

_____ _____

Physician Name NPI #

_____ _____

Physician Signature Facility Name

_____ _____ _____ _____

Street Address City State Zip

_____ _____

Phone Fax

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