Test Requisition Form **Pharmacy.ca Pharmacogenetics DNA Test**

Check all genes required: ☐ CYP2D6, ☐ CYP2C19 ☐ CYP2C9

Price: One Gene $559.00; Two Genes $625.00; Three Genes $695.00.

Physician Section

Physician Information: (You may staple your business card to this form)

Name:_____

Address:_____

City: _____ Province: _____Postal Code: _____

Telephone:_____ Fax: _____

Email address:_____

Patient: Information:

Name:_____ _____

First Last

Address:_____

City: _____ Province: _____Postal Code: _____

Telephone:_____ (Preferred contact number)

Date of Birth: (dd/mm/yy) _____/_____/_____ Gender: _____M _____F

Ethnicity:_____ Country of Birth:_____

Height:_____ Weight:_____

Clinical Concern? _____

Medications that have been problematic for this patient? (use separate sheet if required)

_____

Please list current medications (include regularly taken herbals etc).

_____

_____

_____

Drug allergies:_____

Physician Signature:_____Date:_____

Sample taken by: _____ Date:_____ Time:_____

Patient Section

Patient Section (Patient must complete and sign)

Payment Required*: **One** Gene $559.00; **Two** Genes $625.00; **Three** Genes $695.00.

Cheque enclosed ____ (Make cheque out to Pharmacy.ca.) or

Credit Card: Visa ___ Master Card_____

Card number:_____ Expiry: Month_____ Year_____

Name on the card:_____

Signature of Card Holder:_____ Phone (_____) ____ _____

*This price includes the cost of the kit, the completion of documentation, the taking of the sample, sample shipping, sample conditioning, testing, and reporting of test results to the physician.

Return completed form with sample to Pharmacy.ca in the prepaid Xpresspost envelope provided.

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