TAI DIAGNOSTICS *Monitoring the Health of Transplanted Organs*

TEST REQUISITION FORM

myTAI HEART

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI

SEX	DATE OF BIRTH	DATE OF DEATH	HEIGHT	WEIGHT
☐ MALE ☐ FEMALE	/ /	/ /		☐ lb ☐ kg

RACE: ☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ OTHER

ORDERING INSTITUTION MRN:	INITIAL TRANSPLANT DATE (IF APPLICABLE) / /
ORDERING INSTITUTION SAMPLE ID:	PARENT / GUARDIAN NAME
	PATIENT PREVIOUS NAME(S)
PHONE	EMAIL
ADDRESS	

CITY	STATE	ZIP

ICD-10 / DIAGNOSIS CODES

☐ **REQUIRED:** I understand that this test is currently for use in single organ post-transplant patients, and that it is not intended for patients who:

- are pregnant
- have another transplanted organ
- have post-transplant lymphoproliferative disease
- currently have cancer, or have had cancer within the previous 2 years
- are on mechanical circulatory support

DATE / / SIGNATURE OF MEDICAL PROFESSIONAL

TEST(S) REQUESTED (Select all that apply / see instructions on ordering combinations of tests)

☐ RECIPIENT GENOTYPING (No report issued)	☐ DONOR GENOTYPING (No report issued)	☐ myTAI$_{HEART}$ (Donor Fraction Analysis)	Patients must be 2 months of age or older and at least 7 days post-transplant. Donor and recipient control genotyping must be completed prior to ordering the myTAI$_{HEART}$ Test or results may be delayed. Contact Customer Support for further assistance.
RECIPIENT SAMPLE: ☐ WHOLE BLOOD	DONOR SAMPLE: ☐ WHOLE BLOOD ☐ TISSUE ☐ DNA (Contact Customer Support)	RECIPIENT SAMPLE: ☐ PLASMA ‡	‡ Plasma for the myTAI$_{HEART}$ Test must be isolated from whole blood within 2 hours of collection time indicated above. Document the date, time of spin, and initials of the person who performed the spin procedure below.

RECIPIENT and DONOR samples are only required the first time this test is ordered for a patient and are not needed for subsequent myTAI$_{HEART}$ testing.

1) To order **RECIPIENT GENOTYPING** + **DONOR GENOTYPING**: Select the RECIPIENT and DONOR GENOTYPING boxes and choose WHOLE BLOOD for the recipient sample and WHOLE BLOOD or TISSUE for the donor sample.

2) To order **RECIPIENT GENOTYPING** + **myTAI$_{HEART}$**: Select the RECIPIENT and myTAI$_{HEART}$ boxes and choose WHOLE BLOOD for the recipient sample and PLASMA for the myTAI$_{HEART}$ sample.

3) To order **DONOR GENOTYPING** + **myTAI$_{HEART}$**: Select the DONOR and RECIPIENT boxes and choose WHOLE BLOOD or TISSUE for the donor sample and PLASMA for the myTAI$_{HEART}$ sample.

4) To order all 3 tests: Select boxes for all 3. Choose WHOLE BLOOD for the recipient genotyping sample, WHOLE BLOOD or TISSUE for the donor sample, and PLASMA for the myTAI$_{HEART}$ sample.

	COLLECTION DATE	COLLECTION TIME	PLASMA SPIN DATE	PLASMA SPIN TIME	INITIALS
PATIENT (RECIPIENT) SPECIMEN INFORMATION	/ /	: ☐ AM ☐ PM	/ /	: ☐ AM ☐ PM	
DONOR SPECIMEN INFORMATION	/ /	: ☐ AM ☐ PM			

PROVIDER INFORMATION

LABORATORY / INSTITUTION NAME		
ADDRESS		
CITY	STATE	ZIP
PHONE	SECURE FAX	
LAB CONTACT NAME	ROLE / TITLE	
PHONE	SECURE EMAIL	

TAI DIAGNOSTICS INTERNAL USE ONLY

FORM RECEIVED BY / DATE	SPECIMEN RECEIVED BY / DATE	ASSIGNED TAI MRN#
		ASSIGNED TAI ACCESSION#

TAI DIAGNOSTICS
10101 Innovation Drive. Suite 600. Wauwatosa, WI 53226 • Phone: 1-888-214-3151
Fax: 1-888-300-9674 • Email: customersupport@taidiagnostics.com • www.taidiagnostics.com
Medical Director: Paula E. North, MD, PhD • CLIA# 52D2106958 • CAP# 9515330

ORDERING PHYSICIAN INFORMATION

REQUESTING PHYSICIAN		NPI#
ADDRESS	☐ Check this box if physician address is the same as the Laboratory / Institution Address listed above	
CITY	STATE	ZIP
PHONE	SECURE FAX	SECURE EMAIL

REPORT DELIVERY (Select all that apply)

- ☐ SECURE FAX TO LABORATORY
- ☐ SECURE FAX TO ORDERING PHYSICIAN
- ☐ SELECT IF ADDITIONAL HARD COPY REQUESTED FOR LABORATORY

REQUIRED DOCUMENTATION / SPECIAL INSTRUCTIONS

- ☐ **SPECIMEN COLLECTED IN NEW YORK STATE:** Include New York State Non-Permitted Laboratory Test Request approval letter
- ☐ **MEDICARE:** Include signed ABN Form
- ☐ **RELEVANT MEDICAL RECORDS:** Include comments below or attach records addressing medical necessity
- ☐ **DONOR / RECIPIENT CONTROL ONLY:** I understand that a report will not be issued at this time

OTHER CLINICAL INFORMATION / COMMENTS:

BILLING

☐ **INSTITUTIONAL BILLING** ☐ **SEND INVOICE TO INSTITUTION ADDRESS ABOVE**

BILLING INSTITUTION		PO NUMBER
CONTACT	PHONE	EMAIL
ADDRESS		
CITY	STATE	ZIP
BILLING ACCOUNT NUMBER		SEND INVOICE VIA: ☐ MAIL ☐ EMAIL

☐ **SELF PAY** **TAI DIAGNOSTICS WILL SEND AN INVOICE TO THE ADDRESS LISTED ON PAGE 1 OF THIS FORM**

My signature indicates that I accept financial responsibility for all fees associated with this testing order.

SIGNATURE OF RESPONSIBLE PARTY	PRINTED NAME	DATE / /

☐ **INSURANCE BILLING (U.S. ONLY)** ☐ **I HAVE ATTACHED A COPY OF PATIENT'S PRIMARY AND/OR SECONDARY INSURANCE CARD (FRONT AND BACK)**

INSURANCE COMPANY NAME		
MEMBER#		GROUP #
PATIENT RELATION TO POLICY HOLDER	☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	
POLICY HOLDER NAME	PRIOR AUTHORIZATION NUMBER	

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILTY

I authorize TAI Diagnostics, Inc. to release information received including, without limitation, medical information, which includes laboratory test results to my health plan / insurance carrier and it's Authorized Representatives. I further authorize insurance payments directly to TAI Diagnostics for the services rendered. I understand my health plan / insurance / Medicare / Medicaid carrier may not approve or reimburse my medical services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity or otherwise. I understand I am financially responsible for fees not paid in full by my insurer, including all co-payments, and policy deductibles except, where my liability is limited by contract or State and Federal law. I agree to help TAI Diagnostics resolve any insurance claim issues. My signature indicates I accept financial responsibility for all fees associated with this testing order.

SIGNATURE OF RESPONSIBLE PARTY	PRINTED NAME	DATE / /

This test was developed and its performance characteristics determined by TAI Diagnostics. It has not been cleared or approved by the U.S. Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. This test is used for clinical purposes. It should not be regarded as investigational or for research. This Laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high complexity clinical laboratory testing.

TAI DIAGNOSTICS INTERNAL USE ONLY

TAI® DIAGNOSTICS
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