NeuroQure

ASD INSIGHT TEST REQUEST FORM

PATIENT INFORMATION

Last Name: First Name: M/I:

Date of Birth: Gender at birth: □ MALE □ FEMALE □ UNKNOWN/NOS

Street Address: City: State: Zip:

Mobile Phone No: Email:

Patient Acknowledgement: *I, the undersigned, understand that I am solely responsible for payment for the ASD Insight Test and related services on neuroqure.com. I authorize the release of my medical information to NeuroQure in connection with the ASD Insight Test.*

Patient or Representative Signature: Date:

TEST OPTIONS: □ *ASD INSIGHT TEST*

COLLECTION INFORMATION

Date Collected: Time Collected (include AM/PM):

Collected By (PRINT NAME): Biopsy Site:

Testing laboratory handling instructions: Sample will be cultured and tested at NeuroQure's lab.

MEDICAL NECESSITY:

Please attach a photocopy of Clinical Visit Summary Note if possible

Does the patient have a diagnosis of Autism Spectrum Disorder (ASD) □ Yes □ No □ N/A(not assessed)

Date of Diagnosis, if known mm/dd/yyyy: ___/___/_____

Age of Diagnosis: _____

Method of Diagnosis:

□ ***Developmental Evaluation*** □ ***Clinical Diagnosis***

□ ***ADOS*** □ ***DSM-5*** □ ***Other:*** _____

Does the patient have any other neurodevelopment diagnoses? _____
Has the patient had genetic testing? Yes/No
If yes, what testing and what were the results? _____

Does the patient have a personal or family history of a genetic condition? (Yes/No)
If yes, Name of condition(s) and relationship(s) to child: _____
Does the patient have a family history of ASD? (Yes/No) If yes, please list relationship(s) to patient: _____

TEST OPTIONS: □ *ASD INSIGHT TEST*

AUTHORIZED PROVIDER PRACTICE/CLINIC INFORMATION:

Ordering Clinician Name: **NPI #:**

Practice/Clinic Name: **Practice/Clinic Phone No:**

Practice/Clinic Address: