ASD INSIGHT TEST REQUEST FORM

PATIENT INFORMATION

Last Name | First Name | M/I

Date of Birth (mm/dd/yyyy) | Gender at Birth ☐ Male ☐ Female ☐ Unknown/NOS

Street Address | City | State

Mobile Phone # | 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. NeuroQure may receive and share your medical information with its partners in order to provide the services as described on NeuroQure.com.

PATIENT OR REPRESENTATIVE SIGNATURE | PRINT PATIENT OR REPRESENTATIVE NAME | DATE (mm/dd/yyyy)

TEST ORDERED: ✔ ASD Insight Test

COLLECTION INFORMATION

Date Collected (mm/dd/yyyy) | Time Collected (include AM / PM)

Collected By (PRINT NAME) | Biopsy Site

MEDICAL NECESSITY: **Please attach a copy of the clinic visit summary or other clinical note, evaluation, etc. related to autism diagnostic workup and/or genetic evaluations.**

Does the patient have a diagnosis of Autism Spectrum Disorder (ASD)?

☐ Yes ☐ No ☐ N/A *(not assessed)*

Date of Diagnosis (mm/dd/yyyy)

Age of Diagnosis

Method of Diagnosis *(check all that apply)*

☐ Developmental Evaluation ☐ ADOS

☐ Clinical Diagnosis ☐ 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

AUTHORIZED PROVIDER PRACTICE / CLINIC INFORMATION

Ordering Clinician Name | NPI # | Practice Phone #*

Practice / Clinic Name | Practice Fax #*

Practice / Clinic Address | Practice Email*