Ayass bioscience™
Bridging Science and Precision Patient Care LLC

Cytokine Testing Panel Requisition

1. PATIENT INFORMATION

Last Name | First Name | MI

Address

City | State | Zip

Phone | DOB (mm/dd/yy) | Gender ☐ Male ☐ Female

Email

2. PROVIDER INFORMATION

Clinic Name

Physician Name | NPI#

Address

City | State | Zip | Phone

Fax | Email

Ancestry ☐ Caucasian ☐ African American ☐ Ashkenazi Jewish ☐ Native American ☐ Central/South American ☐ Northern European ☐ Pacific Islander
☐ Western European ☐ Caribbean ☐ Eastern European ☐ Asian ☐ Hispanic ☐ Middle Eastern ☐ Other: _____

3. SPECIMEN COLLECTION

Specimen Type ☐ **Serum**

Date of Collection (mm/dd/yy)

Time of Collection (HH:MM) ☐ AM ☐ PM

4. BILLING INFORMATION

BILL: ☐ Insurance ☐ Medicaid ☐ Medicare ☐ Self Pay ☐ Worker's Comp ☐ Uninsured

Insurance

Name of Policyholder | DOB (mm/dd/yy) | Subsriber ID | Group#

Relationship to Policyholder ☐ Self ☐ Spouse ☐ Dependant ☐ Other_____

Worker's Comp Claim # | Date of Injury (mm/dd/yy)

5. CYTOKINE TESTING PANEL

☐ **Cytokines Panel**

Interferons Viral Replication
IFN-g
IFNa
IFN beta

Broad-Spectrum Protease Inhibitor
Alpha2-Macroglobulin

Growth Factors
G-CSF
GM-CSF
PDGF-AA
PDGF-AB/BB
TGFa
VEGF
FGF basic
PDGF-BB
EGF
Fit-3L
APRIL/TNFSF13
BMP-2

Chemokines
Eotaxin
MIP-3b
MCP-1
MIP-3a
MIP-1a
MIP-1b
GROa
IP-10
GROb
IL-8
RANTES
CXCL6/GCP-2
CXCL5/ENA-78

Interleukins
Granzyme-B
IL-12p70
IL-10
IL-13
IL-15
IL-17A
IL-17E
IL-9
IL-1b
IL-1ra
IL-2
IL-3
IL-33
IL-4
IL-5
IL-6
IL-7
IL-1a
IL-21
IL-11
IL-23
IL-18/IL-1F4
IL-12/IL-23 p40

Tumor Necrosis Factor (TNF) Ligand Superfamily Member
APRIL/TNFSF13
BAFF/BLyS/TNFSF13B

Epithelial Cell Cytokine
TSLP

Interleukin-6 (IL-6) Subfamily Cytokine
Oncostatin M/OSM

Inflammatory Proteins
PD-L1/B7-H1
CD40L

Adipokine
Adiponectin/Acrp30

Epidermal Growth Factor
ErbB3/Her3

Metalloelastase
MMP-12

Tumor Necrosis Factors
TNF-beta
TNFa

Lymphokine
MIF

Apoptosis Cytokine
TRAIL

Adipocyte Protein
FABP4/A-FABP

6. ICD-10 DIAGNOSTIC CODES REFERENCE

7. PATIENT CONSENT

Billing ABN and Patient Plan Information: A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing. This does not apply to specific site analyses. Insurance pre-qualification will not be performed for these tests, unless specifically requested. All tests ordered shall be processed and billed based on payor.
Patient Acknowledgment: I am covered by insurance and authorize Ayass BioScience, LLC to give my designated insurance carrier(s) plan on this form and other information provided by my health care provider necessary for reimbursement. I authorize Ayass BioScience, LLC to inform my Plan of my test results only if test results are required for preauthorization of or payment for reflex/additional testing. I authorize Plan benefits to be payable to Ayass BioScience, LLC. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded immediately to the laboratory.
Patient Consent: My signature below constitutes my acknowledgment that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask questions at any other time.
Patient Consent for Research: ☐ By checking this box I DO NOT consent for the remaining part of my sample to be used for research purposes by Ayass BioScience, LLC.
Personal information will not be shared and will be kept confidential by Ayass BioScience, LLC.
If Signature is other than patient's.

Printed Name_____

(mm/dd/yy)

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE | DATE

8. MEDICAL NECESSITY FOR TESTING

I confirm that the above patient's testing for respiratory pathogens is medically necessary and the result will be used in the medical management and dosing or consideration of medications for this individual patient's therapy.

The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided nessesary testing information to the patient and he/she have consented to respiratory pathogen testing.

Additional Information:

(mm/dd/yy)

HEALTH CARE PROVIDER'S SIGNATURE | DATE

TEST SUBMISSION CHECKLIST

☐ Copy of Patient Demographics
☐ Current Meds List
☐ ICD-10 Diagnosis Codes
☐ Patient's/Provider's Signatures
☐ Copy of Insurance Card (Front/Back)

Collected by:

Print Name

Signature

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