SYN-ONE TEST® REQUISITION FORM

CND Life Sciences®

Please select ONLY ONE of the test choices below. *A box must be marked for the lab to accept the order.*

☐ Syn-One Test panel: Synuclein + IENFD (PGP 9.5) + Skin morphology (H&E) + Amyloidosis (Congo red)
☐ Syn-One Test panel *excluding* Amyloidosis (Congo red): Synuclein + IENFD (PGP 9.5) + Skin morphology (H&E)
☐ Amyloidosis test only: Amyloidosis (Congo red) + Skin morphology (H&E)

All fields are required. Ensure vial labels match the patient information on this form. Incomplete information will result in significant delays.

Patient Information

Legal First Name	Middle Initial	Legal Last Name	Date of Birth (MM/DD/YYYY)

Email Address	Cell Phone Number	Phone Number	Sex at Birth
			Male ☐ Female ☐

Street Address	City	State	Zip Code

Policy Holder First and Last Name, if other than patient	Policy Holder Date of Birth, if other than patient (MM/DD/YYYY)	
		Insured ☐ Self Pay ☐ Client Bill (contracted) ☐ Other _____

Provider Information

Ordering Clinician	Clinician NPI Number	Email Address	Medicare Enrolled
			Yes ☐ No ☐

Practice Name	Practice Phone Number	Practice Fax Number

Practice Street Address	City	State	Zip Code

Patient Status

Select ONE status at the time of biopsy collection. This will be used for billing purposes.

The patient skin biopsy collection procedure was conducted as part of:

☐ An in-office (non-hospital) visit
☐ An ASC (Ambulatory Surgery Center, non-hospital) visit
☐ A registered hospital outpatient visit
☐ A hospital in-patient admission Discharge date (MM/DD/YYYY), or write N/A: _____

ICD-10 Code(s)

Primary diagnosis and relevant diagnoses

Refer to page 2 for details

Biopsy Collection Information

Please make sure the vial labels exactly match the patient and specimen information on this form.

Date of Collection (MM/DD/YYYY) Time of Collection ☐ AM ☐ PM	Clinician Name, if different from above ☐ Same as above Clinician NPI Number, if different from above ☐ Same as above

Biopsy Collection Street Address, if different than above ☐ Same as above	City	State	Zip Code

Biopsy Sites	Side (Select One Side)	Anatomic Location (Select One for Each Specimen)	
Specimen 1	☐ Left ☐ Right	☐ Posterior Cervical – PC	☐ Other Non-standard _____
Specimen 2	☐ Left ☐ Right	☐ Distal Thigh – DT	☐ Other Non-standard _____
Specimen 3	☐ Left ☐ Right	☐ Distal Leg – DL	☐ Other Non-standard _____

PLEASE INCLUDE ALL THE INFORMATION BELOW TO AVOID PROCESSING DELAYS
PUT PRINTED COPIES OF THE REQUESTED INFORMATION WITH THE SPECIMEN SHIPMENT.

✓ **Insurance Cards (Primary and Secondary – Front and Back)** ✓ **Government Issued ID (Front and Back)**
✓ **Relevant Medical Records/Last Visit Note** ✓ **Patient Demographic Information (e.g., Face Sheet)**

Include support in the patient's medical records for why this test is **reasonable and necessary for the diagnosis or treatment** of the patient and describe **how test results may be used to guide the diagnosis or ongoing management** of the patient.

I certify I am authorized to order this test, which is medically necessary and that the results will guide medical management and treatment of this patient. I will make supporting records available detailing the above. I have explained the test to the patient, answered questions, and obtained informed consent from the patient or their authorized representative. The patient has been informed of their right to a copy of this form, which is included in the medical record and can be provided to CND upon request.

The ordering provider is responsible for medical necessity. If a different provider performs the biopsy, their information is documented in biopsy collection information section of this form.

Provider Signature _____ Date _____

For CND Use Only
# of Vials Received _____ Date Received _____ L/R _____ L/R _____ L/R _____ Initials _____

STATEMENT OF PATIENT ACKNOWLEDGEMENT FOR TESTING AND FINANCIAL RESPONSIBILITY

I consent to the skin biopsy procedure and testing explained to me by my provider.

I acknowledge that my financial responsibility will depend on my insurance company's Explanation of Benefits (EOB). I am financially responsible for any costs not paid by insurance, including deductibles, copays, or amounts deemed patient responsibility. I acknowledge that depending on my insurance type, documentation such as Advance Beneficiary Notice (ABN), may be required before I can be billed, and where applicable will be provided to me separately. I also allow CND to work directly with my insurance company on my behalf regarding the determination, denial, and/or any necessary appeal relating to the coverage of services provided by CND. If I receive insurance payment where CND is noted as the intended recipient, I agree to promptly endorse and forward the payment to CND.

I authorize the release of my medical information to CND and my insurance company for purposes related to this test. My personal health information will be handled according to state and federal privacy laws, and I acknowledge receipt of CND's Notice of Privacy Practices at **cndlifesciences.com/npp**

If I am signing on behalf of the patient, I certify that I have legal authority to consent on behalf of the patient.

Patient Signature or Patient's Legal Representative _____ Date _____

PATIENT RESEARCH CONSENT (OPTIONAL)

I understand that my decision to consent for contact regarding research studies will not change the normal processing or billing of my biopsy specimens.

I authorize CND to contact me in the future for potential research studies for which I may be a candidate. I consent for CND to contact me via email, telephone, text message, or by mail.

I understand that I can withdraw my permission at any time by notifying CND in writing or using the contact information provided on their website.

If I am signing on behalf of the patient, I certify that I have legal authority to consent on behalf of the patient.

☐ I consent. ☐ I do not consent.

Patient Signature or Patient's Legal Representative _____ Date _____

ICD-10-CM CODES

For convenience, a list of common ICD-10-CM codes can be found at **cndlifesciences.com/icd-10-cpt-codes**. The ordering clinician is responsible for selecting the appropriate diagnosis based on the patient's signs and symptoms. Only diagnoses that are medically necessary should be submitted, and codes should match with those documented in the patient's medical record. This list serves as a reference tool and is not intended to recommend a specific code for any patient encounter. For a comprehensive list, please refer to the ICD-10-CM manual at **www.cdc.gov/nchs/icd/icd-10-cm**

TEST DESCRIPTION

Please review the Syn-One Test Guidance for Use by visiting this link **cndlifesciences.com/syn-one-test-guidance**

Immunohistochemistry and immunofluorescence tests were developed, and their performance characteristics were determined by CND Life Sciences, Scottsdale, AZ. They have not been cleared or approved by the U.S. Food and Drug Administration. CND Life Sciences, Inc is accredited by the College of American Pathologists (CAP) and holds a CLIA Certificate of Accreditation to perform high-complexity testing.

BIOPSY COLLECTION

Conducting quality skin punch biopsies in a safe, effective manner is a key part of the diagnostic process. Please review the quick reference guide when using the CND Skin Biopsy Collection Kit **cndlifesciences.com/step-by-step**

Please review the Instructions for Use for the CND Skin Biopsy Collection Kit by scanning the QR code or by visiting **cndlifesciences.com/IFU**

CND Life Sciences is here to support you. Please contact CND's Clinical Services team if you have any questions about the test at support@cndlifesciences.com