



Test Requisition Form * Indicates a required field

1. Client Information:

* Ordering Physician: _____ * Clinician/Practitioner Number: _____

2. Molecular Diagnostics: (Checking this box is required for testing)

Select MDx[®] for Prostate Cancer First void post-DRE urine, DRE result, DRE date, PSA, and PSA date are REQUIRED for testing.

3. Patient Information:

* Name (first/middle/last): _____ * Phone: _____

* Address: _____ * City: _____ * Province: _____ * Postal Code: _____

* Date of Birth: _____
Month Day Year

4. Clinical Information: (Required)

* Collection Date*: _____ * Collection date must match date of last DRE
Month Day Year

* Date of Last DRE: _____ * Last DRE: Suspicious for Prostate Cancer Not Suspicious for Prostate Cancer
Month Day Year

* Date of Last PSA: _____ * Last PSA: _____ ng/mL Prostate Volume*: _____ *only if obtained by MRI or ultrasound, otherwise leave blank
Month Day Year

5. Required Billing Information:

Payment available through your doctor's office or through a LifeLabs patient service centre (PSC).

6. Authorization:

* _____ * _____ / ____ / ____
Authorized Signature (No stamped signatures please) Date

Submitting this form constitutes a Certification of Medical Necessity and a certification that you have obtained consent for MDxHealth Inc. to release the test results and relevant medical information to the patient's insurance carrier as part of the coverage and reimbursement process.

7. Patient Consent:

* _____ * _____ / ____ / ____
Authorized Signature (No stamped signatures please) Date

I acknowledge that my personal health information and specimen collected for prostate cancer screening will be sent to LifeLabs and Select MDx for processing. Select MDx is a USA based company which will process your specimen and provide the results back to LifeLabs. LifeLabs will disclose results to the ordering health care provider. Should LifeLabs be asked to use and disclose information about you for another reason, other than as required or permitted by law, LifeLabs will contact you to obtain consent.

MDxHealth Internal Use Only: Total pages _____ Tubes _____

(If available)

Place Patient Label Here

(Barcode provided in the SelectMDx Urine Collection Kit)

Place Provided Barcode Here

Two barcodes are provided in the SelectMDx Urine Collection kit. One barcode is required to be labeled on the urine specimen tube with the patient's name and date of birth, the second label is placed here.