ClearStrand™ASD

For inquiries, contact support@LinusBio.com or
1-877 LINUS BIO (1-877-546-8724)

Test Requisition Form

ClearStrand-ASD is intended to aid health care providers in ruling out autism spectrum disorder (ASD) when it is a concern in patients aged 1 month up to 48 months. It is not intended for a general population. Sample requirement is five strands of hair at least 1.5 inches long.

Ordering Provider Information

Name_____ Provider NPI #_____

Clinic / Practice Name_____ LinusBio Account ID _____

Street Address_____ Provider Email_____

City _____ State _____ Zip _____ Secure Fax_____

Clinic / Practice Phone _____

☐ Include clinic / practice contact delegate for test and follow-up

Contact Delegate Name _____ Contact Delegate Email _____

Patient Information

Name_____

Address _____ Date of Birth (mm/dd/yyyy) _____

City _____ State _____ Zip _____ Sex at Birth _____

Caregiver Information

Name_____

Phone (required)_____ ☐ Check if mobile Caregiver Email _____

Billing Information

☐ Bill to patient (self-pay)

☐ Bill to clinic/employer/other – *If selected, indicate the name or code for the partnership program*: _____

Order Information

☐ **ClearStrand™ASD**

☐ Ship the hair sample collection kit to the patient's address with instructions for use.
Indicate shipping address if different from patient's address _____ City: _____ State _____ Zip

IICD-10 Code(s): *The following codes are listed as a convenience. Ordering provider should report the diagnosis code(s) that best describes the reason for performing the test.*

- ☐ F809 Developmental disorder of speech and language, unspecified
- ☐ F801 Expressive language disorder
- ☐ F802 Mixed receptive-expressive language disorder
- ☐ R620 Delayed milestone in childhood
- ☐ R625 Other and unspecified lack of expected normal physiologic development in childhood
- ☐ Other(s) _____

Comments:

Provider Attestation

I attest that the information provided above is accurate to the best of my knowledge. I am a licensed and qualified healthcare provider and have the authority under applicable state laws (or was delegated authority by an authorized ordering health care provider) to prescribe ClearStrand-ASD and to use the test result in the patient's care.

I attest that the patient's caregiver, identified above, has been informed about the purpose of the test and use of the patient's sample and health information. I certify that this caregiver has signed a HIPAA authorization that allows me to share Protected Health Information with LinusBio for purposes of fulfilling this prescription and of enabling LinusBio to perform ClearStrand-ASD, provide the test result, develop and improve its products and services, and provide customer service.

I further attest that I obtained the caregiver's authorization for the performance and billing of ClearStrand-ASD and agree to provide to LinusBio all patient information necessary for billing, and any related follow-up information for test performance and product-or-quality-related purposes.

Provider / Delegate Signature _____ Date (mm/dd/yyyy) _____

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