**PERSONA BioMED Order Form (Customized Medical Research Service)**

**A PRECISION MEDICINE SERVICE COMPANY**

**Ordered Customized Medical Research Service**

**Code CMRS**

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**Ordering Physician and Informed Consent**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ACCOUNT #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OFFICE/HOSPITAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE: \_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_COUNTRY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OFFICE CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RESULTS DELIVERY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + - I hereby certify as duly licensed physician in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (city, province, country) that:
* I desire to order **Customized Medical Research Service (CMRS™)** developed by PBM, and supported by specializedlaboratory services on biological specimens from patients, for facilitating medical diagnosis and treatment decisions concerning the patient, and advising the patient on health and medical issues.
* I know that clinical performance features from **CMRS** have been determined by PBM, but that they have not yet been cleared or approved by the FDA
* I know that CMRS are experimental and should be regarded as a personalized research on the patient for better understanding patient’s predisposition to oncological and non-oncological diseases or the status of patient’s diseases.
* I know that positive or negative results of laboratory tests should be interpreted in conjunction with all other available clinical and anthropometric data and that final diagnosis and optimal patient management will be my responsibility.
* The patient specified below and/or their legal guardian has been informed of the benefits, risks and limitations of the laboratory test(s) requested. I have answered this person’s questions. I have obtained informed consent from the patient or their legal guardian for this testing.
* I will ensure that patient specimens submitted to PBM are properly requisitioned using PBM’s online ordering system or using the hard copy PBM Requisition form, and are processed, transported and handled in accordance with all applicable statutes, rules and regulations.
* I agree to provide the necessary clinical and anthropometric data from the patient’ medical history for being integrated through a PBM Dx Algorithm™ and computationally processed for generating the Report on the PBM’s CMRS.
* I agree to access all patient test results through PBM’s online database or accept results via fax.
* I agree that clinical records of patients related to the ordering of laboratory tests and/or the Test Reports (collectively the “Data”) shall be regarded as confidential and shall comply with all applicable laws and regulations regarding the use and disposition of such Data.
* Without the prior written consent of PBM, I shall not manipulate, aggregate, integrate, compile, merge, reorganize, regenerate or otherwise use the Data, and shall not provide the Data to any other person or entity, except as required by applicable law.
* The request for the above Laboratory Service for which reimbursement from Medicare, or third-party payers will be sought is medically relevant for the diagnosis, prognosis and treatment of this patient’s condition. I also authorize providing this patient’s test results to the patient’s third-party payer.

PHYSICIAN PRINTED NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and ORDER DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Persona Biomed, Inc.,** 211 N. Union St., Suite 100, Alexandria, VA 22314,

Phone: 703-299-0246; Email: order@personabiomed.com

http://www.personabiomed.com