



**CYP2D6 TESTING**  
(using Amplichip CYP450 Genotyping)  
**Requisition Form**

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**PAYMENT DETAILS**

PLEASE ENSURE YOU COMPLETE ONE OF THE PAYMENT OPTIONS BELOW

<b>VI: PATIENT INFORMATION</b>			
PATIENT NAME:			
NHS/HISTOLOGY NUMBER:			
<b>VII: INFORMATION REQUIRED TO ACCEPT PAYMENT VIA CREDIT/DEBIT CARD</b>			
CARD TYPE			
CARD NUMBER			
CARDHOLDERS NAME			
BILLING ADDRESS (FOR INVOICING)			
CITY	COUNTY	POSTCODE	COUNTRY
VALID FROM (IF PRESENT) (MM-YY)		EXPIRY DATE (MM-YY)	
COST OF TEST(S)			
<b>VIII: INFORMATION REQUIRED TO ACCEPT PAYMENT VIA INSURANCE</b>			
INSURANCE COMPANY			
EXCESS? <input type="checkbox"/> YES <input type="checkbox"/> NO    IF YES PLEASE STATE AMOUNT AND COMPLETE SECTION VIII:			
POLICY NUMBER		AUTHORISATION CODE	
INSURANCE AGENT CONTACT NAME		INSURANCE AGENT CONTACT PHONE NUMBER	