EpiSwitch® **CST** Requisition Form (US)

To order the test, fax the completed requisition form to 1.240.913.5681.
For any questions, please call 1.888.236.8896 or email CST.TEST@myOBDX.com

TESTING MAY BE DELAYED IF REQUIRED FIELDS ARE NOT PROVIDED

For Lab Use	For Lab Use
Order #	Kit Barcode ID #

Patient Information

First Name | MI | Last Name | Medical Record # (optional) | DOB (DD-MMM-YYYY) | Gender: (optional) ◌ F ◌ M

Address | City | State | Postal Code | Country | Primary Phone

Treating Physician Information

Please provide best contact information for case follow-up

Facility or Practice Name | Treating Physician (full legal name) | NPI Number

Facility/Practice Address | City | State | Postal Code | Country | Phone

Oxford BioDynamics Account # (optional) | Email | Fax

Additional Physician to be Copied (optional) | Facility Name (optional) | Email (optional) | Fax (optional)

Test Menu and Specimen Collection

Test	*Description*	*Accepted Specimen Type*	*Minimum Volume Required*
◯ EpiSwitch CST	Prognostic test for likelihood of severe immune reaction following SARS-CoV-2 infection	Whole blood, EDTA Tube	3 mL

Intended Use and Technical Information

Intended Use: The blood test is intended to assess the risk level for developing critical COVID-19 disease resulting from untreated SARS-CoV-2 virus infection. The test is not intended to evaluate an individual's risk of infection.

EpiSwitch COVID-19 Severity Test evaluates six unique Chromosome Conformational Signatures (CCSs) shown to be associated with immunity and are prognostic for critical COVID-19 disease.

Billing Information

Contact Name | Email | Phone

Address | City | State | Postal Code | Country

Test Authorization and Physician Signature

The undersigned certifies that he/she is licensed to order the test(s) listed above and that such test(s) are medically necessary for the care/treatment of this patient

Treating Physician Signature | Printed Name *(full legal name)* | Date