EpiSwitch® **CST** Requisition Form

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 Laboratory Use Only

Patient Information

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

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

Patient History

Has the patient been vaccinated for the SARS CoV-2 virus?

◯ Y ◯ N

Vaccine Given (if known)

Additional Case information (optional)

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 test is intended to identify people who are at the highest risk of critical COVID-19 disease resulting from untreated SARS-CoV-2 virus. People with a high risk of severe or critical disease may benefit from increased infection mitigation and in the event of infection, early use of medications or other interventions. An average risk with a lower score should not be construed as lower severity probability; complications not requiring critical care are possible. The test is not intended to evaluate an individual's risk of infection.

EpiSwitch CST is a quantitative 3D-genomic laboratory derived test for the determination of likely risk of severe immune reactions if a patient is infected with the SARS-CoV-2 coronavirus. The test analyzes six epigenomic features to derive a relative risk score for severe immune reactions following SARS-CoV-2 infection.

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 *(MM/DD/YYYY)*

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