ColoHealth by New Day

Accession Number

NDD_____

PROVIDER INFORMATION

FIRST NAME	MI	LAST NAME	PHONE	EMAIL
John	T	Doe	01234567890	citstestmail@gmail.com

ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP	LIS ID
23 Elfinston street	av	Nevada	Texas	123456	LISPP123

PROVIDER _____ DATE SIGNED _____

PATIENT INFORMATION

FIRST NAME	LAST NAME	DOB	ADDRESS	CITY	STATE	ZIP
John	Deo	07/04/2000	xyz	Brisbane	Aus-tralia	6152

EMAIL	PHONE	GENDER	RACE	ETHNICITY
maintenances-testing@gmail.com	06864489468	Prefer Not To Say	American Indian	Hispanic/Latino

INFORMED CONSENT

CONSENTING TO THIS TEST REQUIRES THAT YOU UNDERSTAND THE FOLLOWING: YOU INDEMNIFY THE ORDERING PHYSICIAN AND THE TESTING LABORATORY, YOU AGREE TO THE REPORTING OF RESULTS TO THE CLIENT LISTED ABOVE AND TO YOUR EMAIL ADDRESS, YOU AGREE TO FOLLOWUP WITH YOUR OWN PHYSICIAN WITH YOUR RESULTS, AND YOU AGREE THAT WE MAY USE YOUR SAMPLE AND THE FOLLOWING INFORMATION FOR RESEARCH PURPOSES. PROVIDING THIS EXTRA INFORMATION WILL PROVIDE SIGNIFICANT INFORMATION FOR THE DEVELOPMENT OF EFFECTIVE DIAGNOSTICS

PLEASE SIGN BELOW IF YOU AGREE AND CONSENT:

Patient Signature: Date Signed:

FOR LAB USE ONLY

Collected Date/Time

1. BLOOD TUBE SPIN (DISABLE BREAK) ☐ _____ _____ _____

2. AIQUIOT PLASMA IN 15ML TUBE

3. 15ML TUBE SPIN ☐ _____

4. AIQUIOT AT LEAST 3.5ML IN 15ML TUBE

5. REFRIGERATE SAMPLES UNTIL COURIERED ON ICE PACKS OR RECOMMENDED COOLING SAMPLES AT LEAST 2 HOURS BEFORE SHIPPING ON ICE PACKS

New Day Diagnostics
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