

PROVIDER INFORMATION

| | | | | | | |
|---------------------------------|---------|------------------|----------------------|---------------------------------|---------------|--------------------|
| FIRST NAME John | MI M | LAST NAME Doe | PHONE 01234567890 | EMAIL citstestmail@gmail.com | | |
| ADDRESS 1 23 Kingsman street | | ADDRESS 2 av | CITY Nevada | STATE Texas | ZIP 123456 | LIS ID LISPP123 |

PROVIDER

DATE SIGNED

PATIENT INFORMATION

| | | | | | | |
|------------------------------|------------------------|----------------------|------------------------------|-------------------------|----------------------------------|---------------|
| FIRST NAME Eric | LAST NAME Rubenford | DOB 11/22/1976 | ADDRESS 18 Palmolive Lane | CITY Nevada | STATE Texas | ZIP 123456 |
| EMAIL ruben.eric@test.com | | PHONE 01234567890 | GENDER Male | RACE Native American | ETHNICITY Not 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

| | | | | | |
|--|--------------------------|----------------------|---------------------|----------------------|----------------------|
| 1. BLOOD TUBE SPIN (DISABLE BREAK) | <input type="checkbox"/> | <input type="text"/> | Collected Date/Time | <input type="text"/> | <input type="text"/> |
| 2. AIQUIOT PLASMA IN 15ML TUBE | | | | | |
| 3. 15ML TUBE SPIN | <input type="checkbox"/> | <input type="text"/> | | | |
| 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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Medical Laboratory Director: Dr. Melissa Chiles, MD (TN LIC# 0000039233)

New Day Diagnostics is a CLIA Approved (CLIA# 44D2184836) Testing Laboratory and ISO 13845:2016 R&D and Medical Device Facility