

PROVIDER INFORMATION

| | | | | |
|----------------------------------|-----------------|-------------------|----------------------|---------------------------------|
| FIRST NAME John | MI T | LAST NAME Doe | PHONE 01234567890 | EMAIL citstestmail@gmail.com |
| ADDRESS 1 23 Elfinston street | ADDRESS 2 av | CITY Nevada | STATE Texas | ZIP 123456 |
| LIS ID LISPP123 | | | | |
| PROVIDER _____ | | DATE SIGNED _____ | | |

PATIENT INFORMATION

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------|
| FIRST NAME | LAST NAME | DOB | PHONE |
| ADDRESS | CITY | STATE | ZIP |
| EMAIL | GENDER <input checked="" type="radio"/> Male <input type="radio"/> Female | ETHNICITY <input checked="" type="radio"/> Hispanic/Latino <input type="radio"/> Not Hispanic/Latino | |
| RACE <input checked="" type="radio"/> American Indian <input type="radio"/> Alaskan Native <input type="radio"/> Asian <input type="radio"/> White <input type="radio"/> African American <input type="radio"/> Native Hawaiian <input type="radio"/> Pacific Islander <input type="radio"/> Other | | | |

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

These steps correspond to steps listed in the instruction guide. See guide for more details.

Collection Date Tech Collecting sample (initials)

Collection Time Tech Processing sample (initials)

Step 1: Time first centrifugation began am / pm

Was brake disabled on centrifuge? ☐ Yes ☐ No

Step 2: Transfer plasma from blood collection tube to 15mL centrifuge tube (check when complete) ☐

Step 3: Time second centrifugation began am / pm

Step 4: Transfer plasma into new cryovial or centrifuge tube (check when complete) ☐

Step 5: If couriering sample: refrigerate samples until couriered on ice packs. If shipping sample: Recommend refrigerating sample for at least 2 hours before shipping on ice packs. (see instructions)

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