

## 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	ADDRESS	CITY	STATE	ZIP
EMAIL	PHONE	GENDER Male	RACE American Indian	ETHNICITY 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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