

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

Ivan

LAST NAME

Evans

DOB

ADDRESS

brook st 34

CITY

kansas

STATE

MS

ZIP

233343

EMAIL

collins.webster@test.com

PHONE

234234234

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)

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Collected Date/Time

2. AIQUIOT PLASMA IN 15ML TUBE

3. 15ML TUBE SPIN

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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

6701 Baum Drive Suite 110 Knoxville, TN 37919

Toll Free (844) EDP-3938 | www.NewDayDiagnostics.com | info@NewDayDiagnostics.com

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