

## Accession Number

NDD

## PROVIDER INFORMATION

|                                 |                 |                  |                      |                                 |                             |
|---------------------------------|-----------------|------------------|----------------------|---------------------------------|-----------------------------|
| FIRST NAME<br>Alexander         | MI<br>M         | LAST NAME<br>Doe | PHONE<br>01234567890 | EMAIL<br>piyushtest98@gmail.com |                             |
| ADDRESS 1<br>23 Kingsman street | ADDRESS 2<br>av | CITY<br>Nevada   | STATE<br>Texas       | ZIP<br>123456                   | PROVIDER ID (NPI)<br>NPI123 |

Physician/Provider

Date Signed

## PATIENT INFORMATION

|  |   |  |       |
|--|---|--|-------|
| FIRST NAME   | LAST NAME   | DOB  | PHONE |
| ADDRESS  | CITY  | STATE  | ZIP   |
| EMAIL  | GENDER<br><input type="radio"/> MALE <input type="radio"/> FEMALE | ETHNICITY<br><input type="radio"/> Hispanic/Latino <input type="radio"/> Not Hispanic/Latino |       |
| RACE<br><input type="radio"/> American Indian <input type="radio"/> Alaskan Native <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 :

Parent 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 <input type="checkbox"/> No <input type="checkbox"/> |                                   |  |
| 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

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)

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