Accession Number

NDD

PROVIDER INFORMATION

FIRST NAME	MI	LAST NAME	PHONE	EMAIL
mike-test1	D	Test1	8655551234	boydmd@hotmail.com

ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP	PROVIDER ID (NPI)
123 Main st		Knoxville	TN	17919	123456789

Physician/Provider _____ Date Signed _____

PATIENT INFORMATION

FIRST NAME	LAST NAME	DOB	PHONE

ADDRESS	CITY	STATE	ZIP

EMAIL

GENDER ○ MALE ○ FEMALE

ETHNICITY ○ Hispanic/Latino ○ Not Hispanic/Latino

RACE ○ American Indian ○ Alaskan Native ○ White ○ African American ○ Native Hawaiian ○ Pacific Islander ○ Other

INFORMED CONSENT

CONSENTING TO THIS TEST REQUIRES THAT YOU UNDERSTAND THE FOLLOWING: YOU INDEMNIFY THE ORDERING PHYSICIAN AND THE TESTINGLABORATORY, 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 ☐ 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)

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