

Accession Number	
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PROVIDER INFORMATION								
FIRST NAME Alexander	MI LAST NAME Doe		PHONE 01234567890		EMAIL piyushtest98@gmail.com			
ADDRESS 1 23 Kingsman street	ADDRESS 2 aV	CITY Nevada		STATE Texas	ZIP 123456	PROVIDER ID (NPI) NPI123		
Physician/Provider	ian/Provider			Date Signed				
PATIENT INFORMATION								
FIRST NAME	LAST NAME		DOB		PHONE			
ADDRESS		CITY		STATE		ZIP		
EMAIL	MAIL GENDER MALE			ETHNICITY  O 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 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 C	ollecting sample (	initials)				
Collection Time		Tech P	rocessing sample	(initials)				
Step 1: Time first centrifuga	ation began	am	ı / 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)								