

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

Ken

LAST NAME

Bridge

DOB

05/05/1976

ADDRESS

23, BK St

CITY

kansas

STATE

MS

ZIP

233343

EMAIL

collins.webster@test.com

PHONE

234234234

GENDER

Male

RACE

Native American

ETHNICITY

Prefer Not To Say

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

Collected Date/Time

1. BLOOD TUBE SPIN (DISABLE BREAK)

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2. AIQUIOT PLASMA IN 15ML TUBE

3. 15ML TUBE SPIN

☐

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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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