

PROVIDER INFORMATION

FIRST NAME John	MI T	LAST NAME Doe	PHONE 01234567890	EMAIL citstestmail@gmail.com
ADDRESS 1 23 Elfinston street	ADDRESS 2 av	CITY Nevada	STATE Texas	ZIP 123456
LIS ID LISPP123				

PROVIDER

DATE SIGNED

PATIENT INFORMATION

FIRST NAME John	LAST NAME Deo	DOB 07/04/2000	ADDRESS xyz	CITY Brisbane	STATE Aus- tralia	ZIP 6152
EMAIL maintenances- testing@gmail.com	PHONE 06864489468	GENDER Prefer Not To Say	RACE American Indian	ETHNICITY 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

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