



Accession Number

Order

Order Number

Date

PROVIDER INFORMATION

FIRST NAME	MI	LAST NAME	PHONE	EMAIL		
ADDRESS 1	ADDRESS 2		CITY	STATE	ZIP	PROVIDER ID (NPI)

Physician/Lab/Clinic Rep _____ Date Signed _____

PATIENT INFORMATION

FIRST NAME	LAST NAME	DOB	ADDRESS	CITY	STATE	ZIP
EMAIL			PHONE	GENDER	RACE	ETHNICITY

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)	<input type="checkbox"/>	<input type="text"/>	Collected Date/Time	<input type="text"/>	<input type="text"/>
2 Aliquot Plasma in 15mL Tube					
3 15 mL Tube Spin	<input type="checkbox"/>	<input type="text"/>			
4 At Least 3.5 mL Aliquot in 15 mL tube					
5 Refrigerate for at least 2 hours before shipping recommended.					

Printed

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)

New Day Diagnostics IS A CLIA APPROVED (CLIA# 44D2184836) TESTING LABORATORY AND ISO 13845:2016 R&D and MEDICAL DEVICE FACILITY