

Accession Number	

PROVIDER INFORMATION						
FIRST NAME Alexander	MI LAST NAME Doe	PHONE 01234567890		EMAIL piyushtest98@gmail.com		
ADDRESS 1 23 Kingsman street	ADDRESS 2	CITY Nevada	STATE Texas	ZIP		
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 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 Collecting sampl	e (initials)			
Collection Time		Tech Processing samp	ple (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)						