ColoHealth by A new day

Accession Number

PROVIDER INFORMATION

FIRST NAME	MI	LAST NAME	PHONE	EMAIL

ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP	PROVIDER ID (NPI)

Physician/Provider _____ 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

Collected Date/Time

1 Blood Tube Spin (Disable Break) ☐ _____ _____ _____

2 Aliquiot Plasma in 15mL Tube

3 15 mL Tube Spin ☐ _____

4 Aliquiot at least 3.5 mL in 15 mL tube

5 Refrigerate samples until couriered on ice packs OR recommend refrigerating samples for at least 2 hours before shipping on ice packs.

New Day Diagnostics
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