DURIN LIFE SCIENCES

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TEST REQUISITION FORM (TRF)

PATIENT LAST NAME	FIRST NAME	M.I.
DOB / /	GENDER ☐ MALE ☐ FEMALE	PATIENT URGENCY LEVEL ID / NUMBER
PATIENT'S ADDRESS	CITY	STATE / ZIP
PHYSICIAN'S LAST NAME	PHYSICIAN'S FIRST NAME	
PHYSICIAN'S PHONE NUMBER	PHYSICIAN'S ADDRESS	CITY / STATE / ZIP
REFERRAL SOURCE (IF APPLICABLE)		
TEST REQUESTED	☐ DURITECT-AD ALZHEIMER'S DISEASE TEST	SAMPLE TYPE ☐ BLOOD EDTA (MIN 2ML)

CLINICAL INDICATION / SYMPTOMS (ENTER SYMPTOMS/MEDICAL HISTORY INDICATING TEST NEED)

ICD CODES	☐ G30.0: ALZHEIMER'S DISEASE WITH EARLY ONSET	☐ G30.1: ALZHEIMER'S DISEASE WITH LATE ONSET	☐ G30.8: OTHER ALZHEIMER'S DISEASE
	☐ G30.9: ALZHEIMER'S DISEASE, UNSPECIFIED	☐ F02.-: DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE	☐ F02.A-: MILD DEMENTIA
	☐ F02.B-: MODERATE DEMENTIA	☐ F02.C-: SEVERE DEMENTIA	

DATE OF REQUEST / /	☐ ROUTINE ☐ URGENT
INSURANCE COMPANY	PHONE NUMBER
INSURANCE COMPANY ADDRESS	CITY / STATE / ZIP
INSURANCE POLICY ID#	GROUP ID# / EFFECTIVE DATE / /

PRE-TEST INSTRUCTIONS (ENTER ANY RELEVANT INSTRUCTIONS FOR PATIENT PREPARATION)

ADDITIONAL NOTES/COMMENTS (ANY ADDITIONAL RELEVANT INFORMATION)