DURIN LIFE SCIENCES

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TEST REQUISITION FORM (TRF)

PATIENT LAST NAME		FIRST NAME	M.I.
DOB	GENDER ☐ MALE ☐ FEMALE	PATIENT ID (MRN ID) #	
PATIENT'S ADDRESS	CITY	STATE	ZIP
PATIENT'S EMAIL	PATIENT'S PHONE NUMBER		
PHYSICIAN'S LAST NAME	PHYSICIAN'S FIRST NAME		
PHYSICIAN'S ADDRESS	CITY	STATE	ZIP
PHYSICIAN'S PHONE NUMBER	PHYSICIAN'S FAX NUMBER	PHYSICIAN'S EMAIL	
REFERRAL SOURCE (IF APPLICABLE)		GROUP/INSTITUTE ID	

TEST REQUESTED	☐ DURITECT-AD™ ALZHEIMER'S DISEASE TEST	SAMPLE TYPE	☐ BLOOD EDTA (MIN 2ML)	COLLECTION DATE	COLLECTION TIME

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)

Approved for use 4/4/2025