CP 3.2.2 GDL GALT Assay - NBS Test Request Form

PLEASE FILL OUT THE FORM COMPLETELY.
THIS INFORMATION IS USED TO SEND OUT TEST RESULTS.

1. This form *must* accompany specimen. Keep a copy of this form.
2. Ship form with attached specimen to Genetic Disease Laboratory (GDL) using GSO.
   DO NOT ship on *Fridays*.

MAIL TO:
GENETIC DISEASE LABORATORY
ATTN: SPECIMEN PROCESSING
850 MARINA BAY PARKWAY C222
RICHMOND, CA 94804

INFANT NAME: _____

BIRTH DATE: _____

SEX: F____ M____

MEDICAL RECORD #: _____

TRANSFUSION HISTORY: _____

FEEDING HISTORY: _____

DATE OF COLLECTION: _____

METABOLIC CENTER (MC) or NICU: _____

PHYSICIAN NAME: _____

PHONE #: _____

FAX #: _____

Center Code or Hospital Code: _____

Date Shipped: _____