CLIENT NAME, CITY AND STATE

TEST REQUEST FORM

CLIENT NUMBER

RESET

CALIFORNIA DEPT. OF PUBLIC HEALTH
GENETIC DISEASE SCREENING PROGRAM
850 MARINA PARKWAY / ROOM F175
RICHMOND, CA 94804

54399-4
FORM# 54399ND

Quest Diagnostics®
Nichols Institute®
33608 Ortega Highway
San Juan Capistrano, CA 92675

CLIENT SERVICES
1-800-553-5445

SPECIMEN PICKUP AND SUPPLIES
1-800-LAB TEST
1-800-522-8378

PATIENT NAME (LAST)	FIRST	M.I.	SAMPLE I.D. NO.	PATIENT STATUS	BILLING CALL NO.
				❑ INPT ❑ OUTPT	

GENDER	BIRTHDATE	PATIENT I.D. NO.	PATIENT'S TELEPHONE NO.	DATE DRAWN			TIME DRAWN		EXPECTED HIGH VALUES
M ◇ F ◇				MO.	DAY	YEAR	AM	PM	YES ◇ NO ◇

REFERRING PHYSICIAN	PHYSICIAN'S TELEPHONE NO.	STIMULATION TEST, SUPPRESSION TEST, OR SAMPLE SITE INFORMATION
J. Puck, MD / S. McGhee, MD		

FOR PATIENT OR THIRD PARTY BILLING COMPLETE INFORMATION REQUESTED BELOW. IF FORM IS NOT COMPLETED, CLIENT WILL BE BILLED.

BILL TO: ❑ CLIENT ❑ PATIENT ❑ INSURANCE ❑ PPO/HMO ❑ W/C ❑ OTHER _____ ATTACH A COPY OF CURRENT INSURANCE CARD (FRONT & BACK)

RESPONSIBLE PARTY _____
RELATION: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER: _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
SS# _____ UPIN: _____
DIAGNOSIS/ICD-9 CM PHYSICIAN PROVIDER # _____

I authorize Quest Diagnostics to release information received including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier, and its authorized representatives. I further authorize my health plan/insurance carrier to directly pay Quest Diagnostics for the services rendered.

SIGNED: X _____

POLICY NUMBER _____ GROUP NUMBER _____
INSURANCE COMPANY'S NAME _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
IF WORKERS COMP., DOI ____ / ____ / ____ EMPLOYER NAME _____
EMPLOYER ADDRESS _____
EMPLOYER TELEPHONE # _____

ORDERING PHYSICIAN'S SIGNATURE - MANDATORY FOR CERTAIN THIRD PARTY PAYORS.

X _____

AUTHORIZATION SIGNATURES AND REQUIRED INFORMATION

Completion of this section is required for NY residents by the NYS Department of Health. Other states may require completion of all or part of this section.

I authorize this specimen for genetic testing and have informed the patient about this test.

X _____
PHYSICIAN SIGNATURE

County State Zip Code
_____
(PATIENT INFORMATION)

I have received information regarding the nature of this genetic testing process.

X _____
Patient (or Guardian) Signature

+ Research/Experimental kits not approved by the FDA.

CODE	X	TEST / PANEL NAME	SAMPLE ♦	CODE	X	TEST / PANEL NAME	SAMPLE ♦

NEWBORN SCREENING FOLLOW-UP TESTING. Please call 1 (800) 642-4657 x4423 BIOCHEMICAL GENETICS LAB with any questions regarding volumes, tube types, sample handling or other issues. Please forward all specimens to Quest Diagnostics San Juan Capistrano – Nichols Institute as a direct send.

ICD-9 Codes _____

Age of Infant @ time of Screen (Days / Hours) _____

Abnormality found by State _____

Clinical History _____

Medications _____

Family History _____

Consanguinity____Yes ____ No

4930CS ( ) SCID Immunophenotyping Panel, Neonatal, Flow Cytometry (AB-L)

Call for minimum volumes, if needed.
Maximum amount of blood to be drawn at this draw is 6cc. _____ Initial _____ Date

WRITE ADDITIONAL TESTS (See Catalog) OR COMMENTS (e.g. BIOLOGICAL HAZARDS) INDICATE TIMING AND VOLUME OF 24 HOUR URINE COLLECTION. ♦ SEE REVERSE SIDE FOR KEY

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