



Repeat Diagnostics

**PART 1: REQUISITION FORM
TELOMERE LENGTH MEASUREMENT**
REQUESTING PHYSICIAN, LAB/INSTITUTION:

Last Name:		First Name:	
Hospital:			
Address:			
City:		State/Province:	Zip/Postal Code:
Phone:	Fax:	Lab Contact:	

PATIENT INFORMATION:

Patient Name:		Sex:	Age:
Patient Hospital ID#:			
Specimen Collection: collect at least 5 ml blood in a standard EDTA, or 7 ml or more if WBC is low or unknown			
Collection Date: (mm/dd/yyyy)	Collection Time: (hh:mm)	Collected by:	

Order: Basic Procedure - provides measurements on total lymphocyte and granulocyte population
 Detailed Procedure - Basic Procedure **PLUS** measurements for B-cells, T-cells and NK cells

RESULTS have a routine turnaround time of approximately 14 days. For expedited service, please contact the lab. Results can be emailed, faxed or both. Your preference:

- Email address(es):
 Fax number(s):

MEDICAL CONSULTATION: Request a written evaluation by a hematopathologist to accompany the test results for an additional \$245. If the space allocated below is not enough, please add information on a separate sheet.

No Yes. If you selected "Yes", please provide pertinent patient information, such as family history, clinical history, current working diagnosis, symptoms and lab investigations, below:

CONSENT:

I hereby authorize telomere length measurement testing for the patient identified in this requisition. I have supplied information to the patient regarding the test, and the patient has given consent for the test to be performed.

Authorized Signature (required):	Date: M M D D Y Y Y Y
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LAB USE ONLY Date(mm/dd/yyyy) Time(hh:mm) RC BY: Cell Count: xE6/ml



1. INSTITUTIONAL BILLING INFORMATION		2. PAYMENT BY CREDIT CARD	
Hospital/Lab Name:		Name as it appears on card:	
Contact Name:		Billing Address:	
Hospital:		City:	
Address:		State/Province:	Zip/Postal Code:
City:		Phone:	
State/Province:		<input type="checkbox"/> MasterCard	Exp. Date:
Zip/Postal Code:		<input type="checkbox"/> Visa	3 digit code:
Phone:		Account Number:	
Fax:		For Telomere Length Measurements and Services performed by Repeat Diagnostics, please charge the above credit card in the amount of \$	
Email:		Date: (mm/dd/yyyy)	
Purchase Order:		Authorized Signature (required):	

3. PAYMENT BY CHECK OR MONEY ORDER

Please place check or money order in the FedEx package, payable to Repeat Diagnostics Inc.

Check or money order enclosed in the amount of: _____ Total: \$ _____

4. INSURANCE BILLING:

Repeat Diagnostics does not bill healthcare insurance companies.

It is important that patients contact their healthcare provider to ensure that they have coverage for this procedure.

A receipt will be sent to the patient at the above billing address for reimbursement purposes.