



TELOMERE LENGTH MEASUREMENT	REQUISITION FORM
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REQUESTING PHYSICIAN, LAB/INSTITUTION	BILLING INFORMATION
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Last Name:	First Name:	[Hospital] [Insurance] [Self Pay]:	
Hospital:		[Department] [Insurance] [Self Pay]:	
Department:		Address:	
Address:	City:	City:	
	State/Zip:	State/Zip:	
Phone:	Fax:	Phone:	Fax:
Ext:	Email:	Other information:	

PATIENT INFORMATION:			
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Patient Name:	Patient ID#:	Sex:	Age:
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SPECIMEN INFORMATION:	*NOTE: do NOT collect samples on THURSDAYS or FRIDAYS as they may not arrive in time for proper processing
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Specimen Type:	
<input type="checkbox"/> Peripheral Blood	<input type="checkbox"/> Other:
Order:	<input type="checkbox"/> <u>Basic Procedure</u> – telomere length is measured provides measurements on total lymphocyte and granulocyte population <input type="checkbox"/> <u>Diagnostic Procedure</u> – telomere length is measured for total lymphocyte and granulocyte populations as well as B-cells, T-cells and NK cells
Collection Date:	Collection Time:
Specimen collected by:	

PREFERENCES:

Routine turnaround time is four weeks. Results can be emailed and/or faxed. Please indicate your preference	
<input type="checkbox"/> Email address:	<input type="checkbox"/> Fax number:
<input type="checkbox"/> Expedited at extra cost. To arrange this, first email test@repeatdiagnostics.com	

COMMENTS:

We learned about Repeat Diagnostics through <input type="checkbox"/> Internet <input type="checkbox"/> hearsay <input type="checkbox"/> publication <input type="checkbox"/> other:

CONSENT:

I hereby authorize telomere length measurement testing for the patient identified in this requisition. I have obtained appropriate informed consent for the test to be performed.	
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Authorized Signature:	Date:

LAB USE AREA DO NOT USE	Specimen Processing Date:	Specimen Arrival Date:
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Recipient:	Comments: