

**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 4 ml blood in a standard EDTA, or 7 ml or more if WBC is low or unknown			
Order: <input type="checkbox"/> <u>Basic Procedure</u> - provides measurements on total lymphocyte and granulocyte population			
<input type="checkbox"/> <u>Detailed Procedure</u> - <u>Basic Procedure PLUS</u> measurements for B-cells, T-cells and NK cells			

Collection Date: | M | M | D | D | Y | Y | Y | Y | Collection Time: | H | H | M | M | Collected by:

RESULTS have a routine turnaround time of four weeks. For *//expedited//* service, please contact the lab. Results are released after receiving payment and can be emailed and/or faxed. 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 \$225. 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: | M | M | D | D | Y | Y | Y | Y | Time: | H | H | M | M | REC BY: Cell Count: xE6/m

PART 2: PAYMENT OPTIONS



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: M M Y Y
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: M M D D Y Y Y Y	
	Authorized Signature (required):	

3. PAYMENT BY CHECK OR MONEY ORDER

100% of the cost of the test, payable to Repeat Diagnostics, is required at time of sample submission.

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.

The CPT code for telomere length measurements is 88271.

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