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| --- | --- | --- |
| Individual Authorized to Complete Test Requisition | Report To Name (ordering physician) **Please Print** | Additional Report Recipient |
| Authorized Person’s Signature | Date | Phone # | Fax # | Email |
| **Test Requested:***□*  Extract and Hold for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (List Specific Test)  | **Report To Address :*Results will be sent to this address*** |
| **Indication for Testing/Clinical Details/Comments:****ICD-10 codes \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**  |
| **Patient Name or Sample ID** | **Gender** | Date ofBirth | MRN | **Date/Time Collected** | **Sample Type** | **TGL Sample Number** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Shaded Area for Translational Genomics Laboratory Use OnlyDate & Time Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Package Integrity: Acceptable? 🞎 Yes 🞎 NoReceived/Numbered By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sample Condition: Acceptable? 🞎 Yes 🞎 No |