



Patient Last, First Name, M.I. (Required)			Date of birth (Required)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Mail results to: (Required)	
Collection date	Collection time	Patient ID	Diagnosis (ICD-9) code				
Referring physician and specialty			Physician UPIN#	Physician NPI#			
Secure fax # for lab results	Physician phone #		Facility phone #				P.O. #
COMPLETE SECTION BELOW ONLY IF BILLING ADDRESS IS DIFFERENT FROM THE 'MAIL RESULTS TO' ADDRESS							
Please Bill: <input type="checkbox"/> Medicare <input type="checkbox"/> Colorado Medicaid <input type="checkbox"/> Patient (Pre-Pay) <input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX <input type="checkbox"/> Discover			Responsible Party (Last, First,):			Medicare (HIC) #	
Name on Card _____			Street Address:			Colorado Medicaid ID #	
Credit Card # _____			City	State	Zip	Social Security #	
Exp. Date _____ CVV Code _____			Telephone #			Patient bills must be prepaid or accompany specimen	

Must be scheduled in advance by calling 800.550.6227, Option 5

BERYLLIUM LYMPHOCYTE PROLIFERATION: (Samples must be received at NJC <24 hours after collection)

___BER1 Beryllium lymphocyte proliferation – blood

___BEBAL Beryllium lymphocyte proliferation – bronchoalveolar lavage (BAL)

RESULT DELIVERY BY:

___ Electronic delivery (contact the Beryllium Business Group to set up an account – 800.423.8891)

___ Fax (fax number must be provided above)

RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby authorize National Jewish Medical and Research Center to release medical information concerning Beryllium lymphocyte proliferation testing to the above named employer.

For de-identified specimens only:

I hereby certify that authorization for release of medical information on this patient is on file at my location.

Signature

Date

COMMENTS:

