



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 #			
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

- _____WARF Warfarin Sensitivity
 Blood Buccal Swab

- _____RESPLX Respiratory Virus Panel PCR
 Nasal wash BAL Nasopharyngeal Swab

- _____MYPCR/CHLU Mycoplasma Pneumoniae PCR/Chlamydomphila Pneumoniae PCR
 Nasal Wash BAL Sputum Biopsy

- _____B2AR Beta 2 Adrenergic Receptor (B2AR) Polymorphism
 Blood Buccal Swab

- _____H1N1 2009 H1N1 Novel Influenza A
 Nasopharyngeal Swab Nasal Swab Throat Swab Nasal Wash BAL

- _____AMD AMD Genetic Panel
 Buccal Swab