LABORATORY TEST REQUISITION FORM

2701 N. DECATUR ROAD
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LABORATORY DIRECTOR

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PATIENT INFORMATION

Patient Name: ______________________________

Date of Birth: ______________ Age: ______ ☐ Male ☐ Female Phone: ______________

Address: ______________________________

City/State: ______________________________

Full Name of Responsible Party: ______________________________

Responsible Party Address: ______________________________

Responsible Party City/State: ______________________________

Responsible Party Phone: ______________ Responsible Party Relationship to Patient: ______________

PHYSICIAN INFORMATION

Requesting MD: ______________ Copy To MD: ______________

Signature ______________ Signature ______________

Address: ______________ Address: ______________

City/State: ______________ City/State: ______________

Phone #: ______________ Phone #: ______________

Fax #: ______________ Fax #: ______________

Diagnosis Code: ______________ Date of onset: ______________

Specimen Date/Time ______________ Specimen Collection Location ______________

Acct. Name If Other than Physician: ______________________________

TEST		Comments
Gold Dot NR2 Antibody	○	
Gold Dot NR2 Peptide	○	

CIS Biotech 2701 N. Decatur Road. Decatur, Ga. 30033 German Khunteev, PhD
Patient Name: ______________ Med Rec #: ______________ Attn. MD: ______________