

Place IDx barcode here  
(Internal use only)



# Laboratory Requisition Form

CLIA ID#: 05D2087906

CAP#: 8958850

Medical Director: William Paxton, MD, PhD, FACP

www.IntrinsicDx.com

Please print clearly and complete entire form. To avoid delays, include the completed form with your shipment.

## PHYSICIAN INFORMATION (required)

IDx ACCT #: \_\_\_\_\_ For returning Customer only. To set up an account, please contact IntrinsicDx.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ NPI #: \_\_\_\_\_

Institution: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_ | Results by:  Fax  Mail

I certify that I have obtained informed consent in writing from the patient or their legal guardian to authorize IntrinsicDx to handle the patient's blood sample for above requested test and I understand that IntrinsicDx will only share the patients results with the requesting physician or their designee.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT INFORMATION (required)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Gender:  Male  Female | Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Fax: \_\_\_\_\_ | Results by:  Fax  Mail

I hereby request that my test results may be reported to \_\_\_\_\_ (Name of Person) by:  Fax  Mail

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Family history of anemia?  Yes  No  Unknown Recent oral iron challenge?  Yes  No If yes:  Pos  Neg Recent transfusion or IV iron?  Yes  No If yes, when: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

## SAMPLE INFORMATION (required)

Date sample collected: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_ AM/PM Initials: \_\_\_\_\_  
MM DD YYYY

Date sample shipped to IntrinsicDx: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sample Type:  Serum  Li-Heparin-Plasma  
MM DD YYYY

View sample collection and shipping instructions at [IntrinsicDx.com](http://IntrinsicDx.com)

## TEST(S) REQUESTED/ORDERED (required)

CRP  Iron  Transferrin Specify Diagnostic Code(s): \_\_\_\_\_  
 Hcpidin \_\_\_\_\_

## PATIENT BILLING INFORMATION (required)

Bill to:  Insurance  Physician  Other: \_\_\_\_\_

If billing to insurance please attach a copy (front & back) of patient's insurance card(s) and complete all requested information below.

Primary Insurance Carrier: \_\_\_\_\_ Medicare, Medicaid or Policy ID #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

Policy holder DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to Patient:  Self  Spouse  Child  Other: \_\_\_\_\_  
MM DD YYYY

Employer/Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

SECONDARY INSURANCE  Yes Please attach a copy (front and back) of patient's secondary insurance card.

I hereby authorize IntrinsicDx Laboratories to provide my designated insurance carrier, health plan or third party administrator (collectively "Plan") the information on this form and other information provided by my health care provider if necessary for reimbursement. I also authorize all benefits of the Plan to be payable to IntrinsicDx. If required by my Plan, I agree to assist in submitting appeals for payment, and understand that I am responsible for any amount not paid by my Plan for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient / Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_