**TANDEM MASS SPECTROMETRY LABORATORY TEST REQUISITION**

**BIOCHEMICAL GENETICS TESTS**

<table>
<thead>
<tr>
<th>TEST LIST</th>
<th>SPECIMEN REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-HYDROXY VITAMIN D TOTAL (WITH D2 AND D3)(LC/MSMS)</td>
<td>2.0 ML WHOLE BLOOD-GOLD TOP SST OR RED TOP</td>
</tr>
<tr>
<td>PKU MANAGEMENT (PHE AND TYR BY LC/MSMS)</td>
<td>FILTER PAPER BLOOD SPOTS (MIN 2 BLOOD SPOTS/CARD)</td>
</tr>
<tr>
<td>DRUG SCREEN, URINE, COMPREHENSIVE (LC/MSMS)</td>
<td>20 ml RANDOM URINE (MIN 4mL)</td>
</tr>
<tr>
<td>DRUG SCREEN, URINE, CONFIRMATION (LC/MSMS)</td>
<td>20 ml RANDOM URINE (MIN 4mL)</td>
</tr>
<tr>
<td>CLINICAL URINE DRUG SCREEN W/ REFLEX TO CONFIRMATION (LC/MSMS)</td>
<td>20 ml RANDOM URINE (MIN 4mL)</td>
</tr>
</tbody>
</table>

**LIST PRESCRIBED MEDICATIONS BELOW FOR DRUG SCREENING**

**PROCEDURAL NOTES**

- WHOLE BLOOD SPECIMENS
  - CENTRIFUGE SPECIMEN
  - SEPARATE PLASMA, SERUM
  - ALIQUOT SPECIMEN INTO POLYPROPYLENE TEST TUBE
  - FREEZE ALIQUOTTED SPECIMEN
  - SHIP FROZEN SPECIMENT ON DRY ICE
- URINE SPECIMEN
  - ALIQUIOT 10.0 mL OF URINE INTO VACUETTE TEST TUBE

**RESULTS**

ALLOW 3-7 DAYS FOR SPECIMEN DELIVERY, PROCESSING AND RESULT INTERPRETATION
### Billing Information

**SELF PAY (Payment in Full from Patient or Guarantor)**

- Check or Money Order
- Credit Card  VISA  MC

#### Payment Information - Indicate One

<table>
<thead>
<tr>
<th>Payment Method</th>
<th>Account Number</th>
<th>Expiration Date</th>
<th>Security No.</th>
<th>Cardholder Name</th>
<th>Cardholder Signature</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**Payment for Medical Care:** It is understood and agreed that the undersigned or a designated agent will be responsible and assume an obligation to pay the Center for Genetic Testing at Saint Francis all costs for genetic evaluation and testing rendered to the person whose name appears within thirty (30) days after having been notified of the amount due and owing or will work out a satisfactory payment plan with the Center for Genetic Testing at Saint Francis. It is further understood and agreed that the undersigned or designated agent will, at all times, remain responsible for the costs of said genetic evaluation and testing.

**Patient Signature:** Must be 18 years or older to sign

**Date**

**Parent/Legal Guardian:** Required if patient is less that 18 years of age or is not legally competent

**Address, City, State, Zip**

**Employer**

**Home Phone Number**

**Work Phone Number**

**Witness Signature**

**Date**

**Insurance (Filed as Courtesy - Patient Ultimately Responsible for Balance of Account)**

- Front and Back Copy of Card, Referral Number (HMO), Referral Date and Authorization Required for Third Party Billing

<table>
<thead>
<tr>
<th>Insured Name</th>
<th>Insured Social Security Number</th>
<th>Insured Date of Birth</th>
</tr>
</thead>
</table>

**Primary Care Physician**

**Employer**

**Insurance Company Name**

**Insurance Company Address, City, State, Zip Code**

**Referral Number**

**Referral Date**

**Effective Date**

**Authorization Number**

**Medicare Number**

**Medicaid Number (Oklahoma Only)**

**Authorization to Release Protected Health Information, Assign Benefits, and Accept Responsibility for My Account:** I authorize any physician or laboratory who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Center for Genetic Testing at Saint Francis. I understand that I am responsible for any co-pay or deductible amounts if the Center for Genetic Testing at Saint Francis is a participant in my health plan. I understand I am fully responsible for payment of my account if the Center for Genetic Testing at Saint Francis is not a participant with my health plan, and my health plan does not reimburse (or only partially reimburses) my medical services due to lack of authorization or medical necessity. The information permitted for release may include records which indicate the presence of a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS), and/or mental health information.

**Patient/Guarantor Signature**

**Date**

**Referring Facility**

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
</table>

**Billing Address**

**Approval Number - If Applicable**

**OSDH**

**Authorization Number**