BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

TEL
1.800.411.4363
FAX
713.798.2787

CONNECT
HELP@BAYLORGENETICS.COM

WBC CYSTINE TESTING REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name ______ Patient First Name ______ MI ______ Date of Birth (MM / DD / YYYY) ___ / ___ / ___

Address ______ City ______ State ______ Zip ______

Phone ______ Accession # ______ Hospital / Medical Record # ______

Biological Sex: ○ Female ○ Male ○ Unknown
Gender identity (if different from above): ______

REPORTING RECIPIENTS

Ordering Physician ______ Institution Name ______

Email (Required for International Clients) ______ Phone ______ Fax ______

ADDITIONAL RECIPIENTS

Name ______ Email ______ Fax ______

Name ______ Email ______ Fax ______

SAMPLE INFORMATION

TEST CODE	TEST NAME	SAMPLE TYPE	SAMPLE REQUIREMENTS	SHIPPING CONDITIONS
4627	White Blood Cell Cystine Test	White Blood Cells	Draw blood in an ACD-solution A (yellow-top) tube(s) and send 5-10 ml (Adults/Children) or 3-5 ml (<2yrs).	Ship at refrigerated temperature in the shipping container provided with freezer gel packs by overnight courier to arrive within 36 hours of collection. Do not heat or freeze.

DATE OF COLLECTION ___ / ___ / ___
Date (MM / DD / YYYY)

BILLING INFORMATION

HPDI	Horizon Pharma
Institution Code	Institution Name

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided biochemical testing information to the patient and they have consented to biochemical testing.

Physician's Printed Name ______

Physician's Signature ______

___ / ___ / ___
Date (MM / DD / YYYY)

OPT OUT OF DISCLOSURE

☐ As the ordering physician of this test, I hereby do not authorize Baylor Genetics to disclose my name, address and telephone number to Horizon Pharma USA, Inc. and its affiliates and their respective agents and representatives. I understand that if this box remains unchecked, my information will be disclosed to Horizon Pharma USA, Inc.