BIOCHEMICAL GENETICS/CYSTINE LAB
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GRANULOCYTE CYSTINE ASSAY

GENERAL INFORMATION

____
Patient Name

_____ / _____ / _______
Date of Birth (MM/DD/YYYY)

Sex: ☐ Female ☐ Male

UCSD Lab Use Only

LOC Code ______ *UCSD Sample #* ______ *Date/Time Received* ______

1. PHYSICIAN INFORMATION REQUIRED

Physician Name ______ UPIN # ______

State License # ______ Hospital / Affiliation ______

Address ______ City ______ State ______ Zip ______

Phone ______ Fax ______ Email address ______

2. PATIENT INFORMATION

CYSTINOSIS MONITORING

Current cystine-depleting therapy or N/A if not on medication ______

Current prescribed dose ______

3. SAMPLE INFORMATION (LAB USE ONLY)

Date of collection _____ / _____ / ________
Date (MM/DD/YYYY)

______ AM PM
Time of collection

DATE, TIME OF LAST 2 DOSES OF MEDICATION

Date ______ Time ______ AM PM

Date ______ Time ______ AM PM

LABORATORY/ POINT-OF-CARE INFORMATION (REQUIRED)

Name ______ Phone ______ Fax ______

Address ______ Email address ______

COMMENTS OR SPECIAL INSTRUCTIONS

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