

PATIENT DEMOGRAPHICS

Patient Name: _____, _____, _____
Last First MI

Date of Birth (MM/DD/YYYY): ____ / ____ / ____

Male Female

BILLING INFORMATION

Physician Name (print): _____

Diagnosis Code(s): _____

Billing information attached - include a copy of insurance card/face sheet

SAMPLE/SPECIMEN INFORMATION

Specimen Type: _____

Collection Date (MM/DD/YYYY): ____ / ____ / ____

Collection Time: _____

Note: Please see test information sheet for acceptable specimen type, collection container, and volume.

ORDERING PHYSICIAN

Physician Name (print): _____

Address: _____

Phone: (_____) _____

Secure Fax: (_____) _____

Date: ____ / ____ / ____

Referring Physician Signature (REQUIRED)

Comments: _____

SHIPPING INFORMATION

Ship to:

Clinical Mass Spectrometry Facility, MLC 7019
Department of Pathology and Laboratory Medicine
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue
Cincinnati, OH 45229-3099

TEST(S) REQUESTED

Therapeutic Drugs:

- Amitriptyline & nortriptyline
- Everolimus
- Sirolimus
- Topiramate

Endogenous Analytes:

- Free Thyroxine (T4)
- Methylmalonic acid (MMA), serum
- Methylmalonic acid (MMA), urine
- Organic acids
- Testosterone, total
- Testosterone, free (**note:** sex hormone binding globulin (SHBG) and total testosterone required)

Newborn Screening:

- Acylcarnitine (blood spots)
- Acylcarnitine (plasma)

Other:

Urine Bile Acids*

Serum Bile Acids*

Drugs of Abuse*

***Note:** Please see applicable test requisition.