BAYLOR MIRACA GENETICS LABORATORIES

PHONE: 800-411-GENE | FAX: 713-798-2787 | www.bmgl.com

SHIP TO: Baylor Miraca Genetics Laboratories
2450 Holcombe, Grand Blvd. -Receiving Dock
Houston, TX 77021-2024
Phone: 713-798-6555

PHENYLALANINE DETERMINATION - BLOOD SPOT (TEST CODE: 4120)

PATIENT INFORMATION

NAME: _____ _____ ____
LAST NAME FIRST NAME MI

DATE OF BIRTH: ____ / ____ / ____
MM DD YY

GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

-OR-
PLACE PATIENT STICKER HERE

HOSPITAL#: _____ ACCESSION#: _____

DATE OF COLLECTION: ____ / ____ / ____
MM DD YY

REPORTING INFORMATION

PHYSICIAN: _____

INSTITUTION: _____

PHONE: _____ FAX: _____

EMAIL (INTERNATIONAL CLIENT REQUIREMENT): _____

ADDITIONAL PROFESSIONAL REPORT RECIPIENTS

NAME: _____

PHONE: _____ FAX: _____

NAME: _____

PHONE: _____ FAX: _____

TEST INFORMATION

☐ 4120 Phenylalanine Determination - Blood Spot

- This test provides quantitative analysis of Tyrosine and Phenylalanine in Plasma.
- This test is useful for the diagnosis and management of patients with PKU.

SPECIMEN REQUIREMENTS:
Blood Spot Requirements: Dried blood spot specimens should be collected by carefully applying a few drops of blood, freshly drawn by finger stick with a lancet from children or adults, or by heel stick with a lancet from infants, onto specially manufactured absorbent specimen collection (filter) paper. The blood should be allowed to thoroughly saturate the paper and air dried for a minimum of 3 hours. Caked or clotted specimens are not acceptable and should not be shipped. Clearly label all samples with patient name, date of birth, and date of sample collection. Samples not clearly labeled will not be accepted for analysis.

SHIPPING CONDITIONS: Ship samples in envelope at room temperature by overnight courier or by first class mail.

REQUIRED: NEW YORK STATE PHYSICIAN SIGNATURE OF CONSENT

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing.

Physician's Printed Name: _____

Signature: _____

Date (MM/DD/YY): _____

BILLING INFORMATION

Complete Billing Information is REQUIRED prior to sample processing and analysis

☐ **SELF PAY (PAYMENT MUST ACCOMPANY SAMPLE):**

☐ CHECK/MONEY ORDER AMOUNT: _____

☐ CREDIT CARD: ◯ AMEX ◯ DISCOVER ◯ MC ◯ VISA AMOUNT: _____

CARDHOLDER NAME: _____

CARDHOLDER SIGNATURE: _____

CARD #: _____

EXP. DATE: _____ CVC CODE: _____ ZIP CODE: _____

☐ **INSTITUTION -** PROVIDE INSTITUTION NAME: _____

ADDRESS: _____ INSTITUTION CODE: _____

CONTACT NAME: _____ CONTACT PHONE: _____

☐ **INSURANCE (Provide a copy of the FRONT/BACK of insurance card)**

ICD10 DIAGNOSIS CODE(S): _____

PERFORM BENEFITS VERIFICATION PRIOR TO TESTING: ◯ YES ◯ NO

ORDERING PROVIDER: _____

INSURED MEMBER'S INFORMATION:

NAME (Last, First, MI): _____

GENDER: ☐ FEMALE ☐ MALE D.O.B. (MM/DD/YY): _____

GROUP#: _____ POLICY #: _____

INSURANCE CO. NAME: _____

INSURANCE CO. PHONE: _____

INSURANCE CO. ADDRESS: _____

I authorize Baylor Miraca Genetics Laboratories to furnish any medical information requested on myself, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to Baylor Miraca Genetics Laboratories. I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for any payment of my account if Baylor Miraca Genetics Laboratories is not a participant with my health plan, and my health plan does not fully reimburse my medical services.

Print Name: _____

Signature: _____ Date: _____

Contact billing@bmgl.com with questions.

LAST UPDATED: 10/2015