REDLABS U.S.A.
"Removing the doubt is part of the cure"
5625 Fox Ave Room 369 • Reno NV 89506
Ph (775) 351-1890 • Fax (775) 682-8517

REDLABS Ref:

Clinic Name/Address

PATIENT NAME: ______________________________

DOB: ____________ SS#/SI#:________________

❒ Male ❒ Female Phone: ________________

Address: ______________________________

City:____________State______Zip:____________

Visa MasterCard Discover AMEX

CARD # ______________________________ Exp Date ____/____

Name as on card: ____________________Phone (___)__________

Signature______________________________

Billing Address ( ): ______________________________

City/ST/Zip: ______________________________

Report Copy to: ______________ Fax #: (____) __________

Collection DATE __________ TIME_________ Initials_______

Physician Signature: ______________________________

ICD CODES: ________ ________ ________

RedLabs USA is a fee-for-service provider and does not bill any insurance carriers except Medicare.
I agree to pay the costs for the analyses requested at the time of service. The receipt for the analyses will be sent to me from RedLabs. If I choose, I can submit this receipt to my insurance carrier for reimbursement. I hereby authorize the laboratory to possibly use my blood samples for research purposes.

Responsible Party Signature______________________ Date____________

MEDICARE ADVANCED BENEFICIARY NOTICE (ABN): Please read ABN on back & provide signature below.
I have read the ABN on the reverse side. If I choose to receive these tests and Medicare denies payment, I agree to pay for the specified tests requested by my physician on this test requisition.

❒ Yes, I want to receive these laboratory tests. ❒ No, I have decided not to receive these laboratory tests.

Patient Signature: ______________________________Date:________________

CODE	TEST	SPECIMEN
	PANEL TESTS	
❒ **CMCP**	Complete CFS Panel (RNAP, RNAA, ELAS, NKCA)	2GR
❒ **MCP1**	Mini CFS Panel (RNAP, RNAA, ELAS)	1GR
❒ **RNAL**	RNase L Panel (RNAP, RNAA)	1GR
❒ **CISP**	Chronic Infection Screen Panel- PCR - Qualitative (VZV, EBV, CMV, HHV-6 [A&B Det], HHV-7, Mycoplasma Fermentans, Mycoplasma Pneumoniae, CHP-Chlamydia pneumoniae)	1GR
❒ **IM01**	Immunobilan (IgA & IgM screen for intestinal pathogens)	1GR
❒ **CYT1**	Cytokine Profile (IL1_, IL2, IL4, IL6, IL10, IL12p70 IFN_, TNF_, TNF_)	1GR
❒ **HLP1**	Heavy Metals Lymphocyte Proliferation Assay - HELP™ Test (Arsenic, Copper, Lead, Platinum, Thiomersal, Palladium, Mercury, Gold, Silver, Aluminum, Beryllium, Nickel, Organic Mercury, Tin)	2GR
❒ **HLP2**	Heavy Metals Lymphocyte Proliferation Assay - HELP™ Test (Chromium 3, Selium, Uranium, Cadmium, Chromium 6, Silicon, Cobalt, Manganese, Titanium)	2GR
❒ **LYEA**	Lymphocyte Enumeration Assay (CD3, CD4, CD8, CD19, CD45)	1GR
❒ **NKCP**	Natural Killer Cell Enumeration & Functional Assay (LU 30) Panel	2GR
	INDIVIDUAL TESTS	
❒ **VZVD**	Varicella Zoster - Qualitative	1GR
❒ **EBVD**	Epstein Barr Virus - Qualitative	
❒ **CMVD**	Cytomegalovirus - Qualitative	1GR
❒ **HHV6**	HHV-6 (includes A&B determination) -Qualitative	1GR
❒ **HHV7**	HHV-7 - Qualitative	1GR
❒ **MYFM**	Mycoplasma Fermentans	1GR
❒ **MYPN**	Mycoplasma Pneumoniae	1GR
❒ **CHLP**	Chlamydia Pneumoniae - Qualitative	1GR
❒ **ELAS**	Elastase	1GR
❒ **NKEA**	Natural Killer Cell Enumeration Assay	1GR
❒ **NKFA**	Natural Killer Cell Functional Assay (LU30)	1GR
❒ **OTHR**	Other:____________________ ____________________	CALL

REQUIREMENTS:
(GR) GREEN TOP SODIUM HEPARIN TUBE

SPECIMENSHIPPING:
4-10mL Whole Blood

Ship overnight at Room Temp

PROCEDURE:
Centrifuge, 10 min./3,000 RPM

Oct 2007