OFFICE USE ONLY Accession #

PeriRx SALIMARK™ OSCC Salivary Gene Expression Test

PATIENT INFORMATION

NAME: ______________________
LAST NAME FIRST NAME

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

(Please select one): FEMALE MALE UNKNOWN

SAMPLE INFORMATION

DATE OF COLLECTION____/____/____
MM DD YY

MEDICAL RECORD #:____________

SAMPLE TYPE: **Saliva**

TEST CODE: **11271**

INFORMATION FOR FACILITY SENDING SPECIMEN:

ORDERING PHYSICIAN'S NAME:____________

NAME OF FACILITY:____________

CONTACT PERSON:____________

ADDRESS:____________

CITY:__________STATE:________ZIP CODE:__________

PHONE:__________FAX:__________

INFORMATION FOR LABORATORY PERFORMING TESTING:

NAME OF LABORATORY DIRECTOR: Kip Kuttner, DO

NAME OF LABORATORY: PrimBio Research Institute, LLC

ADDRESS: 665 Stockton Drive, STE 200I

CITY: Exton STATE: PA ZIP CODE: 19341

PHONE: (610) 458-111 FAX: (610) 458-1114

CLIA #: 39D2085645

INDICATION FOR STUDY

SYMPTOMS (Summarize below):

OTHER (Specify clinical findings below):

CONSENT

For Physician:

❑ By checking this box I am electing the OSCC Salivary Gene Expression Test to be performed on this sample.

Signature: ____________________ Date:____________

For Patient:

I understand by submitting my saliva sample that after testing it may be de-identified and used by PrimBio Research Institute for further development of this test.

Signature: ____________________ Date:____________

BILLING INFORMATION

Credit Card Payment

Select one:
- O AMEX
- O Discover
- O MasterCard
- O Visa

Valid Card #____________________

Exp Date (MM/YY):__________CVC Code:__________

Billing Address:____________________

Cardholder Printed Name:____________________

Cardholder Signature:____________________

PrimBio Research Institute
665 Stockton Dr.
Exton, PA 19341
Phone: 610-458-1112 Fax: 610-458-1114

NEW YORK STATE NON-PERMITTED LABORATORY TEST REQUEST

Under New York State Public Health Law (Article 5, Title V, Section 574) and regulations (Part 58-1.10 (g) of 10NYCRR), laboratories performing testing for any specimens collected in the State of New York must hold a New York State clinical laboratory permit or have test request approval for specific tests.

Because of the rarity of many genetic conditions, testing may not be available through a permit-holding laboratory, or there may be justification for sending to a non-permitted laboratory. New York State approval must be obtained before sending the specimen to a non-permitted laboratory. The ordering provider requesting testing must document that the patient or legal guardian was informed that the laboratory performing the testing does not hold a New York State laboratory permit or that the test is not approved by the Department.

Our laboratory does not yet hold a New York State license. Therefore, you must first submit a completed **Non-Permitted Laboratory Test Request Approval Form** (see the following page) to the New York State Health Department and receive approval for any patient specimen collected in New York that you wish to send to our laboratory for testing. Upon approval, you may send the patient specimen, test requisition form, and a copy of the approval letter for testing to commence.

Notification of approval or rejection will be sent in writing for each request to use a non-permitted laboratory. If rejected, the reason(s) for denial will be explained in the written response. Please contact the Clinical Laboratory Evaluation Program at (518) 485-5378 with any questions.

For Genetic Tests:
Genetic Testing Quality Assurance Program
Wadsworth Center, NYSDOH
Ph: (518) 474-6271
Fax: (518) 486-2693

For All Other Tests:
Clinical Laboratory Evaluation Program
Wadsworth Center, NYSDOH
Ph: (518) 485-5378
Fax: (518) 485-5414