

Client Information (required)

Client Name		
Client Account No.		
Client Phone	Client Order No.	
Address		
City	State	Zip Code

Submitting Provider/Provider Name Information (required)

Submitting/Referring Provider <i>(Last, First)</i>
Fill in only if Call Back is required. Phone () _____ - _____ Fax * () _____ - _____
Provider's National I.D. (NPI)

**Fax number given must be from a fax machine that complies with applicable HIPAA regulation.*

Reason for Referral (required)

ICD-10 Diagnosis Code

Note: It is the client's responsibility to maintain documentation of the order.
New York State Patients: Informed Consent for Genetic Testing

<p>"I hereby confirm that informed consent has been signed by an individual legally authorized to do so and is on file with this office or the individual's provider's office."</p> <p>Signature _____</p>
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Note: It is the client's responsibility to maintain documentation of the order.

Ship specimens to:

Mayo Medical Laboratories
3050 Superior Drive NW
Rochester, MN 55901

Customer Service: 855-516-8404

Visit www.MayoMedicalLaboratories.com for the most up-to-date test and shipping information.

Patient Information (required)

Patient ID <i>(Medical Record No.)</i>		
Patient Name <i>(Last, First, Middle)</i>		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date <i>(Month DD, YYYY)</i>	
Collection Date <i>(Month DD, YYYY)</i>	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Patient's Street Address		
Phone		
City	State	Zip Code

Insurance Information (required)

Subscriber's Name <i>(if different than patient)</i>		
Patient Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____		
Medicare HIC Number <i>(if applicable)</i>		
Medicaid Number <i>(if applicable)</i>		
Insurance Company's Name <i>(if applicable)</i>		
Insurance Company's Street Address		
City	State	Zip Code
Policy Number		
Group Number		

MML Internal Use Only

Billing Information

- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing related questions:
800-447-6424 (US and Canada)
507-266-5490 (outside the US)

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Patient Name <i>(Last, First, Middle)</i>	Client Order No.
Birth Date <i>(Month DD, YYYY)</i>	

CONSULTATION/MORPHOLOGY EVALUATION

PATHC Pathology Consultation (submit stained slides and block)

HPWET Hematopathology Consultation, MML Embed (submit core biopsy, clot section and bone marrow aspirate)

HPCUT Hematopathology Consultation, Client Embed (submit bone marrow aspirate and embedded core biopsy and clot section)

ERYTHROCYTES: ENZYMOPATHIES

G6PD Glucose-6-Phosphate Dehydrogenase (G-6-PD), Quantitative, Erythrocytes

GPI Glucose Phosphate Isomerase, Erythrocytes

G6PDB Glucose-6-Phosphate Dehydrogenase (G6PD) Full Gene Sequencing

HAEVP Hemolytic Anemia Evaluation

NEEVP Neurologic Enzyme Evaluation

P5NT Pyrimidine 5' Nucleotidase, Blood

PKLRG Pyruvate Kinase Liver and Red Blood Cell (PKLR) Full Gene Sequencing and Large Deletion Detection

PK Pyruvate Kinase, Erythrocytes

EEEVP Red Blood Cell (RBC) Enzyme Evaluation

ERYTHROCYTES: GENERAL

HGB_Q Hemoglobin, Qualitative, Urine

PLHBB Plasma Hemoglobin, Plasma

RTIC Reticulocytes, Blood

ERYTHROCYTES: HEMOGLOBIN DISORDERS

REVE Erythrocytosis Evaluation

HAEVP Hemolytic Anemia Evaluation

HBELC Hemoglobin Electrophoresis Cascade, Blood

HPFH Hemoglobin F, Red Cell Distribution, Blood

SDEX Hemoglobin S, Screen, Blood

HGBCE Hemoglobin Variant, A2 and F Quantitation, Blood

MEVP Methemoglobinemia Evaluation

P50B Oxygen Dissociation, P50, Erythrocytes

THEVP Thalassemia and Hemoglobinopathy Evaluation

ERYTHROCYTES: HEREDITARY ERYTHROCYTOSIS

BPGMM 2,3-Bisphosphoglycerate Mutase, Full Gene Sequencing Analysis

REVE Erythrocytosis Evaluation

EPO Erythropoietin (EPO), Serum

HEMP Hereditary Erythrocytosis Mutations

P50B Oxygen Dissociation, P50, Erythrocytes

ERYTHROCYTES: IMMUNOLOGY

ABYSR Antibody Screen with Reflexed Antibody Identification, RBC

CATR Cold Agglutinin Titer, Serum

BTR Isoagglutinin Titer, Anti-B, Serum

PLINK PNH, PI-Linked Antigen, Blood

ERYTHROCYTES: MEMBRANE DISORDERS

HAEVP Hemolytic Anemia Evaluation

RBCME Red Blood Cell Membrane Evaluation, Blood

FRAG Osmotic Fragility, Erythrocytes

ERYTHROCYTES: METHEMOGLOBIN

MET Methemoglobin and Sulphemoglobin, Blood

METR Methemoglobin Reductase, Blood

MEVP Methemoglobinemia Evaluation

LEUKOCTYES

MUR Lysozyme (Muramidase), Plasma

LYMPHOCYTES

ALPS Alpha Beta Double-Negative T Cells for Autoimmune Lymphoproliferative Syndrome

CRGSP Cryoglobulin and Cryofibrinogen Panel, Serum and Plasma

ATR Isoagglutinin Titer, Anti-A, Serum

LCMS Leukemia/Lymphoma Immunophenotyping by Flow Cytometry

NKSP Natural Killer (NK)/Natural Killer T (NKT) Cell Subset Panel

VISCS Viscosity, Serum

METABOLISM: MEGALOBLASTIC ANEMIA

FOL Folate, Serum

GAST Gastrin, Serum

MHCZ Methylmalonic Aciduria and Homocystinuria, cbIC Type, Full Gene Analysis

MHDZ Methylmalonic Aciduria and Homocystinuria, cbID Type, Full Gene Analysis

MMAP Methylmalonic Acid (MMA), Quantitative, Plasma

MMAS Methylmalonic Acid (MMA), Quantitative, Serum

MMAU Methylmalonic Acid (MMA), Quantitative, Urine

ACASM Pernicious Anemia Cascade

B12 Vitamin B12 Assay, Serum

FB12 Vitamin B12 and Folate, Serum

METABOLISM: METALS

CERS Ceruloplasmin, Serum

FERR Ferritin, Serum

FECHZ Ferrochelatase (FECH) Gene, Full Gene Analysis

HFE Hemochromatosis HFE Gene Analysis, Blood

FEC Iron and Total Iron-Binding Capacity, Serum

TRSF Transferrin, Serum

NEZPP Zinc Protoporphyrin, Blood

**ADDITIONAL TESTS
(INDICATE TEST NUMBER AND NAME)**