Telorisk

Requisition and Consent Form

Barcode

*All required fields MUST be filled in.

Patient Information			
First Name*		**Last Name***	
Date of Birth*	D D / M M / Y Y Y Y	**Sex***	□ M □ F
City / State / Country		**MRN**	
Additional Comments	Please note any additional clinical history		
Primary Ethnicity*	□ African □ Asian □ Caucasian □ Hispanic □ Others		
Physician Information			
Clinic / Hospital Name*		**Department***	
Name*		**Email**	
Specimen Information			
Collection Date*	D D / M M / Y Y Y Y	**Sample Type***	□ EDTA WB 3.0 ml

- I consent for providing above described personal information. ☐ Confirmed
- I was fully explained and understood the limitations of this test and the confirmations prior to requesting a test, and hereby I request this test. ☐ Confirmed

Date D D / M M / Y Y Y Y **Name** (Signature)

GC Genome

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