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<i>Do not write here</i>	LAB COPY
ACCESSION #:	
BATCH ID #:	
COPY SENT TO MD/CLIENT:	

PATIENT	Medical Record #:		
	Last Name:	First Name:	Middle Initial:
	SSN:	Birth date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
	Street:		City:
	State:	ZIP:	Phone:

PHYSICIAN	Street:		CLIENT	Street:	
	City:			City:	
	State:	ZIP:		State:	ZIP:
	Phone:	Fax:		Phone:	Fax:

PANELS / TESTS REQUESTED		Date of Collection:	Time of Collection:
MULTIGEN ANTENATAL PANEL	ANTENATAL TESTS		
Group B streptococcus (GBS) <input type="checkbox"/>	Pregnancy test <input type="checkbox"/>	Rubella IgG <input type="checkbox"/>	
Neisseria gonorrhoea <input type="checkbox"/>	ABO/Rhesus Blood Grouping <input type="checkbox"/>	TORCH screen <input type="checkbox"/>	
Chlamydia trachomatis <input type="checkbox"/>	Antibody screen w/reflex <input type="checkbox"/>	RPR w/reflex confirm <input type="checkbox"/>	
Trichomonas vaginalis <input type="checkbox"/>	CBC <input type="checkbox"/>	Hep C ab <input type="checkbox"/>	
Herpes simplex (1 & 2) <input type="checkbox"/>	Urinalysis <input type="checkbox"/>	Hep B S ag w/reflex <input type="checkbox"/>	
	Urine culture <input type="checkbox"/>	HIV <input type="checkbox"/>	
MULTIGEN THROMBOPHILIA PANEL	THROMBOPHILIA TESTS	Other Tests/History:	
Factor V (Leiden) <input type="checkbox"/>	Protein C activity <input type="checkbox"/>		
Factor II (Prothrombin) <input type="checkbox"/>	Protein S activity total/free <input type="checkbox"/>		
MTHFR (C677t) <input type="checkbox"/>	Antithrombin III activity <input type="checkbox"/>		
MTHFR (A1298c) <input type="checkbox"/>	Anti-phospholipid antibodies <input type="checkbox"/>		

BILLING	Primary Insurer:	Insurance Company:
	Address:	Policy I.D. #:
	MEDICARE #:	MEDICAL #:
	Attach copy of Insurance Card (Front and Back)	Diagnosis Code:
	Bill: <input type="checkbox"/> Client <input type="checkbox"/> Patient <input type="checkbox"/> Insurance	