



PHYSICIAN PRACTICE

Practice Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

After Hours Phone: _____

☐ Physicians Office ☐ Nursing Home (NH) ☐ Assisted Living Facility (ALF) ☐ Treatment Facility (TF)

CONTACT INFORMATION (responsible for specimens on Physician's behalf)

Contact Name: _____

Phone: _____ Email: _____

Preferred Results Delivery Method: ☐ Website Self Retrieval ☐ Fax ☐ Email

SPECIMEN INFORMATION

☐ BLOOD ESTIMATED WEEKLY SPECIMENS: _____☐ TOXICOLOGY ESTIMATED WEEKLY SPECIMENS: _____☐ COGNITIVE PROGRAM ESTIMATED WEEKLY SPECIMENS: _____☐ PGX ESTIMATED WEEKLY SPECIMENS: _____☐ RPP ☐ GPP ☐ UTI ESTIMATED WEEKLY SPECIMENS: _____☐ WOUND PCR ☐ NAILS PCR ESTIMATED WEEKLY SPECIMENS: _____☐ PATHOLOGY ESTIMATED WEEKLY SPECIMENS: _____☐ SARS-COV-2, PCR ESTIMATED WEEKLY SPECIMENS: _____

Pick up by:

☐ Fedex ☐ UPS ☐ Courier

HOURS OF OPERATION & SPECIMEN COLLECTION TIME

DAYS	OFFICE HOURS	SPECIMEN COLLECTION TIME
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

Each of the Ordering Providers hereby acknowledges and agrees by their signatures on this Enrollment Form, that: (i) he/she agrees to the use of his/her signature for electronic signature purposes within any EMR / LIS portal and (ii) he/she agrees the use of his/her electronic signature as the legal equivalent of his/her manual/hand-written signature and each consents to be legally bound. SMA agrees to maintain copies of all records containing electronic signatures as legally required.

ORDERING PROVIDERS :

Physician's Name: _____

Credentials: ☐ MD ☐ DO ☐ NP ☐ ARNP ☐ APRN ☐ CNP ☐ PA

Individual NPI _____

I hereby consent to the use of my signature for electronic signature purposes within any EMR / LIS portal.

PHYSICIAN SIGNATURE (please sign inside this box with black ink)	DATE SIGNED
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Physician's Name: _____

Credentials: ☐ MD ☐ DO ☐ NP ☐ ARNP ☐ APRN ☐ CNP ☐ PA

Individual NPI _____

I hereby consent to the use of my signature for electronic signature purposes within any EMR / LIS portal.

PHYSICIAN SIGNATURE (please sign inside this box with black ink)	DATE SIGNED
--	-------------

Physician's Name: _____

Credentials: ☐ MD ☐ DO ☐ NP ☐ ARNP ☐ APRN ☐ CNP ☐ PA

Individual NPI _____

I hereby consent to the use of my signature for electronic signature purposes within any EMR / LIS portal.

PHYSICIAN SIGNATURE (please sign inside this box with black ink)	DATE SIGNED
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Physician's Name: _____

Credentials: ☐ MD ☐ DO ☐ NP ☐ ARNP ☐ APRN ☐ CNP ☐ PA

Individual NPI _____

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PHYSICIAN SIGNATURE (please sign inside this box with black ink)	DATE SIGNED
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PANIC VALUES

- ☐ Call All Panic Values between _____ am and _____ pm
- ☐ Fax All Panic Values
- ☐ Custom Panic Values

Analyte Name			
Call Value	>__ <__	>__ <__	>__ <__