City of Hope LABORATORIES
Dennis D. Weisenburger, MD
Chairman, Department of Pathology, CLIA #05D0665695

**Tax ID:95-1683875**

**Clinical Molecular Diagnostic Laboratory**
1500 East Duarte Road
Northwest Building, Second Floor, Room 2236
Duarte, CA 91010-3000
Phone 888-826-4362 Fax 626-301-8142
cmdl@coh.org http://cmdl.cityofhope.org

# CMDL Institutional and Out of pocket billing TRF

## Patient Information

| Last Name | First name | Middle Initial | Female ○ | Male ○ | Date of Birth |
|---|---|---|---|---|---|
| | | | | | |

| Street Address, State, ZIP | Specimen Number or Code | Date Collected |
|---|---|---|
| | | |

| Phone Number | Mother's Country or Region of Origin | Father's Country or Region of Origin | Ethnicity |
|---|---|---|---|
| | | | |

Comments (note any consanguinity)

Marital Status: Single ○ Married ○ Divorced ○ Separated ○ Widowed ○

ICD9 Codes (required for insurance):

**Diagnosis / Clinical Findings / Family History ( please attach the pedigree if available, completed Patient Information Form and/or clinic notes)**

| Patient history | Family history |
|---|---|
| | |

## Billing information (institutional or out of pocket)

○ **Bill to Referring Institution**

Institution Name and billing address

| Contact Name | Contact Phone |
|---|---|
| | |

| Contact Email for Copy of Results | Contact Fax Number |
|---|---|
| | |

○ **Out of Pocket Payment**

○ **Check Enclosed** (please make check to "City of Hope CMDL"& write SSN on check)

○ **Charge to Credit card**

MasterCard ○ VISA ○ Discover ○ American Express ○

| Card Holder Full Name | Account Number | Expiration Date | US Dollar Amount |
|---|---|---|---|
| | | | |

Card Holder Signature

Billing Notes

## Referring Physician and Genetic Counselor (or other contact) Information

| Referring Physician Name | Referring Physician UPIN | Genetic Counselor (or other contact) Name and Title |
|---|---|---|
| | | |

| Referring Physician Phone | Physician Institution and Address | Counselor/Contact Phone | Contact Institution and Address |
|---|---|---|---|
| | | | |
| Referring Physician Fax | | Counselor/Contact Fax | |
| Referring Physician Email* | | Counselor/Contact Email* | |

* Copy of results will be sent electronically via our secure system; email address also required for status updates

## Tests Ordered (multiple tests are done simultaneously unless the order of reflexive testing is noted here)

PLEASE SELECT A TEST FROM THE DROP-DOWN LIST OR CHECK IT IN AN ATTACHED TEST LISTING - DO NOT WRITE IN THE TEST

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Comments:

**As the referring physician named above, I certify that the patient whose specimen is being submitted for analysis has been informed of the benefits and limitations of the laboratory test(s) requested, has had the opportunity to have all questions answered adequately, has been offered genetic counseling as appropriate, and has satisfied the informed consent requirements of my institution.**

**Referring Physician Signature (required):**_____ **Date:** _____

| **For laboratory use only** | Kindred #: | Accession #: | Specimen Type and Amount: |
|---|---|---|---|
| | Comments: | | |

Save Form to Your Computer | Print | Reset ALL Entries