



MEDICAL DIAGNOSTIC LABORATORIES, L.L.C.

REQUEST FOR SPECIMEN COLLECTION KIT TO BE SENT TO A PATIENT

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Disclaimer - I have advised the patient that kit(s) will be received within 3-5 business days excluding today

Signature of person **completing** this form: _____ Date: _____

Ordering Physician Name:	Test(s) Being Requested:
Type of Specimen Collection Kits	# of Kit(s) Requested
Biopsy Collection Kit Biopsy Bottle with buffer	
Body Fluid Collection Kit (1) Red Top Tube, Styrofoam & Cold Pack	
ELISA Collection Kit (1) SST & Styrofoam	
PCR Collection Kit (2) ACD-A Tubes & Styrofoam	
PCR/ELISA Collection Kit (2) ACD-A Tubes, (1) SST & Styrofoam	
Requisition <input type="checkbox"/> Gynecology <input type="checkbox"/> Urology <input type="checkbox"/> Standard	
Swab Specimen Collection Kit Please check one: <input type="checkbox"/> OneSwab™ <small>(Reg. U.S. Pat. & Tm. Off.)</small> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> UroSwab™	
Urine Collection Kit for PCR Sterile Container, Styrofoam & Cold Pack	
Western blot Kit (1) SST, Pour-off Vial, Styrofoam & Cold Pack	

Please fill in the applicable areas and fax to: (609) 570-1010 (Please allow 3-5 business days for processing and delivery)

For MDL Office Use Only - Please Do Not Write Below This Line

Date Received: _____ Person Filling Order: _____ Order #: _____

Toll Free: (877) 269-0090 ■ Fax: (609) 570-1050 ■ www.mdlab.com