IBS*chek*
By Commonwealth Diagnostics International, Inc.

Barcode

BLOOD TEST
LABORATORY REQUISITION FORM

Test Information (*Not available in NY*)

Test Request (check all that apply) $199 per Test:

☐ IBS*chek*® (anti-CdtB and anti-vinculin)

Sample Type: *EDTA Whole Blood/Plasma*

ICD-10 Code:

□ K58.0 (Irritable Bowel Syndrome w/ diarrhea)*

□ Other(s) _____

*These codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describe the reason for performing the test, regardless of whether the code is listed above or not.

Provider Information

Practice Name | Provider Name | NPI # *(Required, US only)*

Address | City | State/Prov. | Zip/Post. | Country

Provider Phone #

Provider Email

Provider Signature *(Required)* | Date

Patient Information

First Name | MI | Last Name | Date of Birth | Sex: (circle one) M F

Address | City | State/Prov. | Zip/Post. | Country

Phone # | Email

Date of Specimen Collection *(Required for Processing Sample)*

Credit Card Information

Credit Card Number

Expiration Date | CVV

Patient Billing Zip (*if different from above*)

1. By signing this requisition form, I authorize Commonwealth Diagnostics International, Inc. ("CDI") to use my personal health information necessary for the delivery of the products and services being received. I further authorize the sharing of my personal health information to the listed provider(s) and/or individual(s) named on this form.
2. I understand that CDI does not accept, or submit to, any form of insurance for this service. Therefore, I elect to self-pay for this service and I understand that I am responsible for the full cost of these products and services prior to their delivery.
3. I understand that by providing credit card information on this requisition form, I am authorizing CDI to charge the credit card for the full cost of the test stated on this form. If paying by credit card is not preferred, I will prepare a check payable to Commonwealth Diagnostics International, Inc. for the full cost of this test stated on this form and include it when I ship my sample. If I have any questions, I will contact CDI's Billing Department at 1(888)258-5966, option "3."

Patient Signature *(Required)* | Date

Blood Samples will be Subject to REJECTION if:

- The blood sample is coagulated, grossly hemolyzed, or contains high lipid content
- Shipping instructions were not followed
- The blood sample arrives without two (2) unique identifiers

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