

# Requisition Form

(Please Print)

v4.0/15 direct Ref. Forms

MorNuCo Laboratories 1201 Cumberland Ave. Ste. B West Lafayette, IN 47906 Phone: 765-464-1583 Fax: 765-464-8769	CLIA #15D2033610	Assigned by MorNuCo Laboratories
		OCB # _____  Date received _____

Requesting Clinician	Date
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## 1. PATIENT INFORMATION

Last Name:	First:	Middle:	<b>Unique Identifier*</b> xxxx-DAL
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Date of Birth* Mo. Day Yr.	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
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Has the patient ever been diagnosed with cancer? Yes \_\_\_ No \_\_\_ If Yes: Date \_\_\_\_\_ Type(s) \_\_\_\_\_

Is the cancer Active or in Remission? Active \_\_\_\_\_ Remission \_\_\_\_\_ N/A \_\_\_\_\_

If no diagnosis of cancer, what is the suspected type of cancer? \_\_\_\_\_

Basis for diagnosis and/or suspicion of cancer (previous tests)?

Mammogram     X-ray     Blood Test     Pathology Report  
 Thermogram     Tomogram     MRI     ONCOblot  
 Other: \_\_\_\_\_

Has this patient taken the ONCOblot test before?  Yes  No Previous ONCOblot Unique Identifier? \_\_\_\_\_

Is there a history of familial cancer?  Yes  No Which cancers (list any that apply)? \_\_\_\_\_

Other comments: \_\_\_\_\_

## 2. PATIENT CONSENT

### Declaration: TO BE READ AND SIGNED BY BOTH PATIENT AND PHYSICIAN

**Test Description:** The ONCOblot® blood serum test reveals the presence of cancer-specific ENOX2 proteins to verify the tissue of origin of cancers as early as stage 0, identify the origin of metastasized cancers of unknown primary, and confirm cancer recurrence. ONCOblot's sensitivity and specificity for cancer screening within the general population has not yet been determined. The ONCOblot® test results are provided to medical professionals for interpretation and are not intended to replace current standards of care.

I understand that while the incidence of false positives or false negatives is low, as with any test all results must be reviewed by a qualified physician taking my symptoms and medical history into account.

**The ONCOblot test is not covered by Medicare, Medicaid or other health insurance providers.**

Patient Authorization:	Physician Authorization:
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RETURN RESULTS <input type="checkbox"/> Email: <input type="checkbox"/> FAX:
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- **\*REQUIRED:** Please include the unique identifier (above) and Date of Birth on the serum transfer tube.
- Mor-NuCo Laboratories will assign an internal OCB number upon receipt of a sample.
- **Please keep a copy of this requisition form for your records.**

Please complete back side of this Requisition Form



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## 3. REQUIRED DOCTOR/CLINIC INFORMATION

Clinician/Dr. Name:		NPI/ID:	
Street address:			
City:		State:	
		ZIP Code:	
Phone No:		Today's Date:	

## 4. SERUM SAMPLE INFORMATION (to be filled out by the laboratory)

Date Of Birth:	/ /	Gender:	<input type="checkbox"/> M <input type="checkbox"/> F
Date Collected:	/ /	Collection Site:	
Collected By:		Address:	
Phone no:			
Phlebotomist's Signature:		City, State, Zip:	

## 5. COLLECTION AND SHIPPING INSTRUCTIONS

- Collect blood in a Tiger top tube with serum separator.
- Allow sample to stand upright at room temperature for 30 minutes to clot blood.
- Centrifuge sample for 15 minutes at 2,500 RPM (serum should be free of hemolysis).
- Aliquot serum into plastic transfer tube and then freeze.
- **Label transfer tube with unique identifier and date of birth (found on front of this form). No personal information.**
- Place frozen tube, frozen icepack and paper towel into specimen bag.
- Insert this completed Requisition Form into the outer pouch of the specimen bag.
- Enclose specimen bag in Specimen Return Box and close securely with tape.
- Seal the Specimen Return Box inside the FedEx Clinical Pak.
- Ship samples **Monday through Thursday** only. (Serum may be kept frozen until able to ship.)

Ship all samples on ice packs **overnight** FedEx to:  
MorNuCo, Inc.  
1201 Cumberland Avenue Ste. B  
West Lafayette, IN 47906  
(765) 464-1583 (p)  
(765) 464-8769 (f)

## PAYMENT INSTRUCTIONS

1. Clinician's office will be invoiced upon receipt of the ONCOblot<sup>®</sup> kit by MorNuCo/ONCOblot labs).
2. Check payable to MorNuCo may be included in the kit.
3. **Credit Card:** No \_\_\_\_\_ Expiration \_\_/\_\_/\_\_ Billing Zip Code \_\_\_\_\_

Name on Card \_\_\_\_\_ Cardholder Signature \_\_\_\_\_ CVV# \_\_\_\_\_

**We do not accept insurance or Medicare/Medicaid at this time.**