

Test Request Form



- Apolipoprotein E Genotyping
- PAI-1 Gene Polymorphism (4G vs. 5G)
- Dihydropyrimidine Dehydrogenase (DPD)
(GT to AT causing skipping of exon 14)
- Prothrombin 3' UT (G20210A)
- eNOS T-786C Mutation
(Endothelial Nitric Oxide Synthase)
- Factor V (Leiden) Mutation
- Glycoprotein IIIa (A1 vs A2 polymorphism)
- Stromelysin-1 5A vs. 6A
- MTHFR C677T Mutation
- MTHFR A1298C Mutation
- †*Warfarin Metabolism Panel
(VKORC1, CYP2C9*2 & CYP2C9*3)
Height required for warfarin starting dose. Height: _____
†Not approved in the State of New York
*See our web site for the dosing algorithm

Patient Information: (REQUIRED)

Name : _____
Address : _____
SSN : _____
DOB : _____
SEX : Male _____ Female _____
ICD-9 code(s): _____
Draw Date: _____ MR#: _____
Diagnosing: _____

Physician Information: (REQUIRED)

Name : _____
Address : _____
Phone : _____
Fax : _____
Physician's UPIN #: _____
NPI # : _____

Bill To: (REQUIRED)

Hospital/Facility/Clinic/Patient (please circle one)

Name : _____
Address : _____

Send Results To: (REQUIRED)

(results cannot be sent directly to the patient)

Name : _____
Address : _____
Phone : _____
Fax : _____

Note: We currently cannot bill the insurance companies.

For additional information please visit our website: www.mdl-labs.com.

Informed Consent : ___ YES ___ NO (Required for all N.Y. State residents for genetic testing.)

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