HCG REFERENCE SERVICE
REFERRAL FORM

THIS FORM MUST BE PRINTED ON YOUR COMPUTER (select print option), AND THEN COMPLETED AND SENT ALONG WITH SERUM AND URINE SAMPLES, PATIENT HISTORY, AND PAYMENT, IN ALL REFERENCE SERVICE CONSULTATIONS

Name of Patient:____

Patient address for receipt____

____

Patient daytime contact phone number______________________________

Date of Birth of Patient____

Most recent hCG Result_____________________________________**mIU/ml**

Date of hCG results____

Laboratory that performed test____________________________________

Managing physician____

Telephone____

FAX for reports____

Physician's E-mail____

Please fill out the following:

1. Have you provided serum and urine **YES / NO**

2. Have you include brief history or records **YES / NO**

3. Have you included means of payment **YES / NO**

(MAKE CHECK OUT TO: Laurence A. Cole, USA hCG REFERENCE SERVICE)

4. Is it acceptable if your samples are stored and used for future research and future test development **YES / NO**

While we will provide a receipt and information needed for insurance reimbursement we cannot guarantee that any specific company will completely cover all out-of-pocket costs.