35 N. E. Industrial Road, Suite B100, Branford, CT 06405
Phone: 2032083464; Email: info@wrenlaboratories.com

FORMS MUST BE FULLY COMPLETED.

INCOMPLETE FORMS WILL DELAY SAMPLE PROCESSING AND RESULTS.

Patient Information

Last Name	First	MI	Date of Birth__/__/__	Gender: M F
Street Address				
City	State	Zip Code	Phone Number	Email
Responsible Party Name		Relationship to Patient: Self Child Spouse Other		
Bill To: (Circle One)	Insurance	Patient(Self-Pay)	Client's Office	

Insurance Information: **Complete below only if NOT attaching a copy of the front and back of insurance card(s).**

Primary Insurance Info:	Secondary Insurance Info:
Subscriber Name	Subscriber Name
Provider Name:	Provider Name:
Provider Address:	Provider Address:
ID#/Group#:	ID#/Group#:

Self Pay: **Please fill out credit card information below, or indicate you're billing address if different from above.**

Credit Card Type:_________________________ **Card Number:**______________________________ **Exp. Date:**___________________

Alternate Billing Address: ____

Provider & Test Information: **You *must* include Provider's Name and Facility.**

Ordering Provider's Full Name:____ **NPI Number:**_______________________________

Provider's Facility:____ **Phone Number:**_____ _____________________

Provider's Address:____

____ **E-mail:**____________________________________

Diagnosis/Symptoms (Provide ICD-9/10 Codes):____

Note: When ordering tests which Medicare reimbursement will be sought, providers should only order tests that are medically necessary for the diagnosis or treatment of the patient. Medicare generally does not cover routine screening tests or those for research purposes only.

Please indicate below the test(s) to be performed and reason(s) for testing (Tick the Box):

___________***NETest**** (CPT Code: 0007M) (*Whole Blood required for test*)

__________***Chromogranin A**** (CPT Code: 86316) (*Plasma required for test*)

- ☐ **Pre- Surgery**
- ☐ **Post-Surgery (☐ Months)**
- ☐ **Monitoring (Watchful waiting)**
- ☐ **Monitoring (Somatostatin analog)**
- ☐ **Symptoms (Disease Not Confirmed)**
- ☐ **Monitoring (Other Therapy)**
- ☐ **Chemotherapy** ☐ **Target Therapy** ☐ **PRRT**

Physician Signature: By signing below, I have obtained the necessary Patient Authorization for genetic testing as required by State and Federal Law.

Physician Signature:____Date:___________________________

Patient Authorization: I authorize release of any medical information necessary to process a claim and request that payment benefits be made to Wren Laboratories.

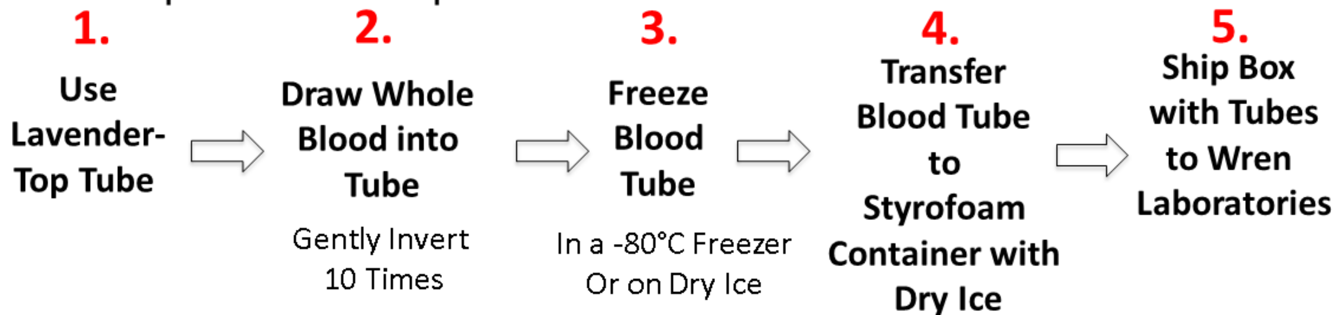
Patient/Authorized Signature:____Date:___________________________

WREN Laboratories

Specimen and Transport Requirements

NETest Collection Instructions

1. Use supplied Lavender-Top EDTA tube
2. Draw Whole Blood into tube
3. After collection, mix thoroughly by gently inverting tube 10 times.
4. Freeze specimen immediately at -80°C.



Chromogranin A Collection Instructions

1. Use supplied White-Top Plasma Preparation Tube
2. Draw Whole Blood into tube
3. After collection, mix thoroughly by gently inverting tube 10 times.
4. Spin tube in centrifuge at approximately 3000 RPMs for 5 minutes at room temperature to separate cells from plasma.
5. Freeze specimen immediately at -80°C.

Transportation

FROZEN samples should be sent via FEDEX to Wren Laboratories for analysis. **IT IS IMPERATIVE THAT THESE ARE NOT SHIPPED ON A FRIDAY TO AVOID COMPROMISING THE BLOOD SAMPLE.**

Please note:

1) **5 kg (~10 lbs) dry ice is needed**.
2) Dry ice and samples should be placed in the polystyrene box and then placed into the cardboard box.
   - The polystyrene box should contain **ONLY** the samples and dry ice
3) Please adhere the enclosed DRY ICE LABEL to one end of the container.
4) Place the provided FEDEX LABEL (in the plastic wallet) ON TOP OF THE CARDBOARD BOX AFTER SEALING.

Shipping address:

Wren Laboratories LLC
35 NE Industrial Road, Suite B100
Branford, CT 06405 USA
Phone 203-208-3464