



688 East Main Street, Branford, CT 06405  
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**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: \_\_\_\_\_

**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 ICD10 Code):** \_\_\_\_\_

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):**

_____ <b>NETest*</b> (CPT Code: 0007M)	_____ <b>Chromogranin A*</b> (CPT Code: 86316)	
(Whole Blood required for test)	(Plasma required for test)	
<input type="checkbox"/> Pre- Surgery	<input type="checkbox"/> Monitoring (Watchful waiting)	<input type="checkbox"/> Symptoms (Disease Not Confirmed)
<input type="checkbox"/> Post-Surgery ( <input type="checkbox"/> Months)	<input type="checkbox"/> Monitoring (Somatostatin analog)	<input type="checkbox"/> Monitoring (Other Therapy)
_____ Date of Last SSA Dose	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Target Therapy <input type="checkbox"/> PRRT

**Blood Collection Date:** \_\_\_\_\_

**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.

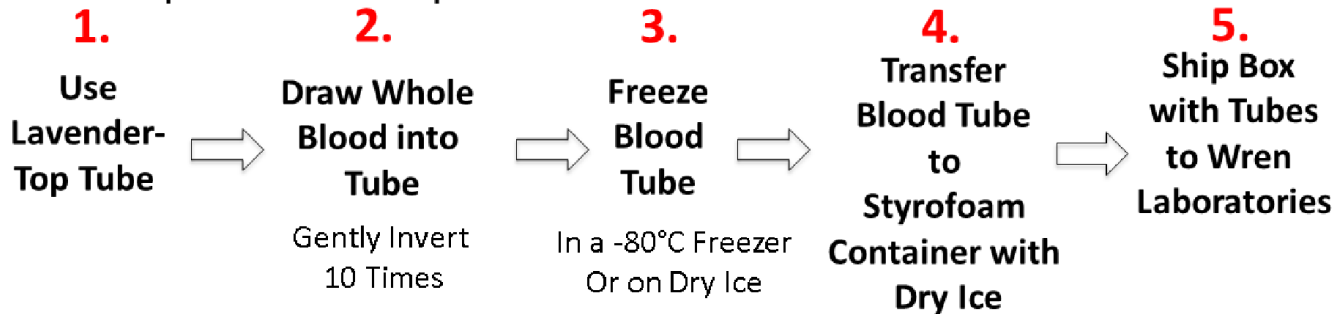
Patient/Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 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.

Prepare Sample in < 30 minutes



### 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  
688 East Main Street  
Branford, CT 06405 USA  
Phone 203-208-3464