LUXDiagnostics

CLIENT INFORMATION FORM

ACCOUNT INFORMATION

ACCOUNT NAME:	CONTACT NAME:
PHONE:	CONTACT TITLE:
FAX:	CONTACT PHONE:
ADDRESS:	CONTACT EMAIL:

PANELS ORDERED

- ☐ Toxicology
- ☐ Molecular STI Panel
- ☐ Molecular UTI Panel
- ☐ Molecular Vaginitis Panel
- ☐ Molecular Wound Panel
- ☐ Molecular Fungal Panel
- ☐ Molecular GI Panel
- ☐ Respiratory Pathogen Panel
- ☐ COVID-19/FLU/RSV Panel
- ☐ COVID-19
- ☐ Comprehensive Blood Panels
- ☐ Tuberculosis Testing
- ☐ Culture & Sensitivity Testing
- ☐ Comprehensive PGx Panel
- ☐ Pain PGx Panel
- ☐ Cardio PGx Panel
- ☐ Neuro PGx Panel
- ☐ Psych PGx Panel
- ☐ Other Testing Requests:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

BILLING TYPE

- ☐ Insurance
- ☐ Client Bill (Approval Required)
- ☐ Patient

REPORTING PREFRENCE

- ☐ Fax to Practice
- ☐ Email to Practice
- ☐ Email to Provider

SHIPPING INFORMATION

- ☐ Courier Pick-up (Georgia Only)
- ☐ Courier Pick Up Time:
  _____
- ☐ FedEx Shipping
- ☐ UPS Shipping
- ☐ Saturday Deliver
- ☐ Delta Dash (For large volume)

CRITICAL CONTACT INFORMATION

CONTACT NAME:	EMAIL:
PHONE:	NOTES:

LUXDiagnostics

PHYSICIAN AUTHORIZATION FORM

PORTAL ACCESS: INDIVIDUALS AUTHORIZED TO ELECTRONICALLY ACCESS PORTAL AND ORDER TESTS	
NAME:	EMAIL:
NAME:	EMAIL:
NAME:	EMAIL:
NAME:	EMAIL:
NAME:	EMAIL:

PHYSICIAN SIGNATURE RECORD

PLEASE INCLUDE ALL PROVIDERS WHO ARE AUTHORIZED TO ORDER LAB TESTING. THE INDIVIDUAL LISTED BELOW ARE AUTHORIZED TO SIGN PATIENT TEST REQUISITIONS, LIMITED TO MD, DO, PA OR APRN (CNP). RNS ARE NOT ALLOWED TO ORDER OR SIGN FOR LAB TESTING WITHOUT PHYSICIAN;S AUTHORIZATION (SEE ABOVE.)

LAST NAME	FIRST NAME	NPI #	SIGNATURE	DATE

I UNDERSTAND AND HEREBY ACKNOWLEDGE THAT I WILL ONLY ORDER TESTS THAT I BELIEVE TO BE MEDICALLY NECESSARY TO ENSURE PATIENT COMPLIANCE WITH THE THERAPY THAT I HAVE PRESCRIBED.