Orphalan Innovation for Orphan Diseases

Patient Name (Last, First name): _____

Date of Birth: _____ **Sex:** ☐ **M** ☐ **F** **Race:** _____

Street Address: _____

City: _____ **State:** ____ **Zip Code:** _____ **Phone:** _____

☐ Ship kit directly to the patient

MRN: _____ **Collection Date:** _____ **Collection Time:** _____

Ordering Provider Name and Credential (Print) or Submitting Laboratory Information:

_____

Street Address: _____

City: _____ **State:** ____ **Zip Code:** _____

Phone: ( ) _____ **Fax: ( )** _____

Email_____

I hereby authorize the laboratory to perform the test selected as indicated. I understand and acknowledge that I am ordering the test that I believe to be medically necessary for my patient.

Provider Signature: _____ **Date:** _____

Test Ordered:
☒ Total Copper and Non-Ceruloplasmin bound Copper (NCC-Sp)
Acceptable samples: Blood collected in metal free serum tube (Royal blue, red top)

For laboratory use only:
Date/Time received: _____ Received by: _____

Laboratory information
Name: Quotient Sciences (Alnwick) Limited
Address: Taylor Drive Alnwick, Northumberland
NE 66 2 DH, United Kingdom