1565 McGaw Ave. Suite B
Irvine CA, 92614
Phone: (800) 820-8803
www.ihdlab.com

Remote Blood Draw Request Form

All fields are required

Client Section (fill out by client)

c CLIENT INFORMATION			
Center Name			
Center Location			
Physician Name			
d PATIENT INFORMATION			
Patient Last Name		Patient Address:	
Patient First Name			
Patient D.O.B		City: State: Zip code:	
Patient Phone #		Email:	
e DRAW DATE AND TIME	Although IHD makes the best attempt to accommodate the requested date and time, they are not guaranteed.		
Preferred Date(s)			
Preferred Time			
Results Requested by Date			
Kit configuration	Single Kit Couple Kit		
f APPROVAL	By signing, the requestor authorizes IHD to arrange remote draw.		
Requestor Name		Email:	
Requestor Signature			
Date			
g SUBMISSION	Submissions should be faxed or emailed within 3-5 business days prior to requested draw date.		
Fax to	1-949- ô ò í r õ ï ò ó		
Email to	kits@ihdlab.com		
h QUESTIONS (optional)	Call 1-949-612-9883		
Note:			

IHDSection (filled out by IHD)

QC of Kit by Internal IHD Tean	
SST:	UPCOMING EXPIRATION DATE:
LAV:	PREPARED DATE:
URINE CUP:	PREPARED BY:
APTIMA TUBE:	QC'D BY:
GREEN TUBE:	NOTES:
OTHER:	

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