

## REQUISITION FORM: SCHEDULED VISIT

The WHITE copy of the requisition form goes with the room temperature specimens to the central laboratory. The BLUE copy of the requisition form goes with the frozen specimens. The YELLOW copy of the requisition form is to be retained at your site for your file. You may receive additional labels indicated as \*\*\*START LABEL\*\*\* and \*\*\*END LABEL\*\*\* attached to the back of each requisition form, these can be discarded.

Your account number and investigator information will be pre-printed here.

Complete this box with required demographic information at each visit.

Q\* Solutions

ABC PHARMA - PROTOCOL 1234-567 - VISIT 2 /or/ VISIT 2 & 3

ACCT NO. 82004739    REQ NO. 372732    4    KIT NO. YH372732

TESTING, USA

7600 TYRONE AVE  
VAN NUYS CA 91405

1-818-8302206

STUDY ID: 3CP

FORM CODE: SDPR

SITE #: 999

Issued: 10 Sep 2015 by HOST

DEMOGRAPHIC SECTION

Complete all boxes in this section, failure to do so may delay reports.

Primary #: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Secondary #: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Gender: Male  Female

Date of Birth: DAY MONTH YEAR  
30 years will be imputed by Quest Diagnostics

Collection Date: DAY MONTH YEAR

Collection Time: [ ] [ ] [ ] [ ] 24 hours

Fasting Status: YES  NO

**\*\* PEDIATRIC STUDY \*\*    \*\* PEDIATRIC STUDY \*\*    \*\* PEDIATRIC STUDY \*\***

Refer to sample handling guidelines in the investigator manual for complete sample collection, handling and shipping instructions.

SCHEDULED VISITS: The visits premarked below /or/ Indicate (X) the visit below:

Visit:	1	2	3
1	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Required Test(s)	Specimen / Transport Tube	Ship
PT/INR	1 mL Plasma, 3.5 mL Sarstedt Vial	FR
Estradiol <small>For females of childbearing potential only, check box if required.</small>	1 mL Serum, Clear Push Cap Tube	FR
Chemistry C- Reactive Protein	1 mL Serum, White Cap Tube	RT
HIV 1/2 Ab w/reflex to confirmation	1 mL Serum, White Cap Tube 3 mL Serum, White Cap Tube	
Folate	1 mL Serum, White Cap Tube	FR
Hematology	2 mL Whole Blood, Lavender Tube	RT
Glucose Predose Time: [ ] [ ] [ ] [ ] 24 hours	1 mL Plasma, White Cap Tube	RT
Glucose 1 Hr Postdose Time: [ ] [ ] [ ] [ ] 24 hours	1 mL Plasma, White Cap Tube	RT
Urinalysis	10 mL Urine, Yellow Urinalysis Tube w/preservative	RT
Urine Drug Screen	20 mL Urine, Screw Cap Conical Base Tube	

IMPORTANT: All labels are customized per test, please complete subject / patient identifier on every label. Make sure to adhere to the correct label on the samples sent to the Central Lab.

**\*\* NO TESTING OUTSIDE OF PROTOCOL \*\***

White Copy - Room Temperature (RT)    Blue Copy - Frozen (FR)    Yellow Copy - Site Record    517923

4215 emp

4215 emp

451789 (SDP folder)

Mark visit when required.

All labels are test specific. Put a label on every specimen sent back to the central laboratory. Please complete the subject/patient identifier and any other required demographic fields on every label. Discard ALL unused labels/labeled tubes.