

# Sample Submission Form – Fungitell® Assay



**LABORATORY HOURS:**

Monday – Friday

8:00 AM – 5:00 PM

Closed Saturday & Sunday

**SAMPLE RECEIVING:**

Monday - Saturday

8:00 AM – 7:00 PM

Closed Sunday

**PHYSICIAN / ACCOUNT INFORMATION**

ACCOUNT NAME / ADDRESS

Name\*:

Attn\*:

Address\*:

Phone\*:

Fax\*:

E-mail:

**PATIENT / SAMPLE INFORMATION**

**PATIENT INFORMATION (COMPLETE OR AFFIX LABEL)**

Last Name\*:

First Name\*:

M.I.

D.O.B.\*:

Sample Number\*:

Medical Record Number:

Date Collected:

ICD9 Code:

*\*Required Fields*

**ORDERING PHYSICIAN OR AUTHORIZED PERSON**

Name\*:

Address:

Phone:

Fax:

**SEND RESULTS TO:**

ACCOUNT

PHYSICIAN

Results will be sent to Account or Physician as indicated above.

**SAMPLE SHIPPING INSTRUCTIONS**

- Use Red-Top Tubes.**  
Please provide at least 0.5 mL of serum separated from the clot and **shipped cold or frozen on ice packs or dry ice.** Serum should be shipped in a sterile, clean, screw-cap plastic vial (most cryogenic vials certified DNase and RNase free are typically suitable for use). **Do not send serum in glass tubes.**
- Heel and finger stick samples are inappropriate.
- Secure the vial closure with Parafilm® or tape.**
- Next day shipping is required.** Samples shipped on Fridays must be clearly marked for Saturday delivery to prevent delivery delays which may result in samples that are unsuitable for testing.
- Avoid contact between the serum and potential sources of (1→3)-β-D-Glucan contamination, including cellulosic filters, gauze, paper, cardboard, and cotton swabs.
- Hemolyzed, lipemic, and icteric samples are not suitable for testing.**
- Samples must be shipped in accordance with Federal Shipping requirements for Clinical Diagnostic Specimens.

**Note: During the warm summer months, use insulated shipping containers (e.g. Styrofoam™ liners) and extra cold packs or dry ice when shipping samples.**

**PHYSICIAN'S COMMENTS:**

*\*Required Fields*

Medicaid, Medicare, Third-party payers not accepted.

**BILLING\***

Acct. Name:

Attention:

Address:

Acct. #:

**METHOD OF PAYMENT**

Direct Bill (PO # if applicable)

Credit Card

Visa

Mastercard

American Express

Number:

Expiration Date:

Name on Card:

Signature:

**BEACON LAB USE ONLY**

Date Received:

Received by:

Receipt Comments:

Sample Receipt #:

Test File #:

Reviewer:

(signature and date)



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Sample Submission Form

BLF-004 Rev. 10