NOVALAB
Reference Medical Lab

Alzheimer's Disease Requisition

87 Berdan Ave #2A, Wayne NJ 07470
Phone: (973) 832-7902, Fax: (973) 832-7980

PATIENT INFORMATION:

LAST NAME

FIRST NAME

DATE OF BIRTH (MM/DD/YYYY) **SEX** ☐ Male ☐ Female

ADDRESS

CITY / STATE /ZIP CODE

PHONE / FAX

EMAIL

REFERRING PHYSICIAN INFORMATION:

PHYSICIAN NAME

NPI

CLINIC / FACILITY NAME

ADDRESS

CITY / STATE /ZIP CODE

PHONE / FAX

EMAIL

SPECIMEN INFORMATION

Date Collected: **Time Collected:**

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purpose for this patient.

Ordering Clinicain Signature: _____ _____ **Date:** _____

TESTS

☐ PLASMA p-TAU 217 (6003)
☐ PLASMA Nf-L (6002)
☐ PLASMA GFAP (6001)

☐ AD PANEL (6000)
PLASMA GFAP (6001)
PLASMA Nf-L (6002)
PLASMA p-TAU 217 (6003)

ADDITIONAL CLINICAL INFORMATION

Chronic Kidney Disease:	☐ Yes	☐ No	☐ Unknown
Hypertension:	☐ Yes	☐ No	☐ Unknown
Diabetes:	☐ Yes	☐ No	☐ Unknown
History of cancer:	☐ Yes	☐ No	☐ Unknown
History of stroke:	☐ Yes	☐ No	☐ Unknown
History of myocardial infarction:	☐ Yes	☐ No	☐ Unknown