

Mail the completed TeloYears Order Form along with the patient's sample in the envelope provided.

Please complete fields below. Please make photocopies of this order form for your records.

TELOYEARS CUSTOMER INFORMATION

Name (Last): _____ (First): _____ (M.I.): _____
Birthdate (MM/DD/YYYY): / / Sex: M F
Phone #: () - Email: _____
Address: _____
City: _____ State: _____ Zip: _____

ORDERING DOCTOR/PROVIDER INFORMATION

Name (Last): _____ (First): _____
Office Phone #: () - Office Fax #: () -
Office Address Line 1: _____
Office Address Line 2: _____
City: _____ State: _____ Zip: _____
Email (Optional): _____

SAMPLE COLLECTION DATE**IMPORTANT!**

Mail the blood sample the same day it is collected.

Date of Collection (MM/DD/YYYY): / / _____

USE OF SPECIMENS

Telomere Diagnostics retains customer samples indefinitely for validation, educational purposes and/or research, maintaining the confidentiality of each sample. Customers may decline the use of submitted sample(s) for research; refusal does not impact diagnostic testing or reporting of results. Customers may withdraw consent for use of samples at any time by contacting the Telomere Diagnostics Laboratory Director via mail at the address below. Telomere Diagnostics will not pay royalties to customers if a commercial product is developed during research using their samples.

I do not wish to allow my sample to be used for test validation, education or research. Therefore I am checking this box to indicate that the sample should be used for the test specified above and will be destroyed after 60 days. Customer initials: _____

TDX INTERNAL ONLY
Shipment Tracking #: _____ Receive Date (MM/DD/YYYY) ____/____/_____