Referral Lab
New York Presbyterian Hospital
622 West 168th Street,
PH 3W, Room 355
New York, New York 10032
Tel: 212.305.6245 Fax: 212.342.3544

CLINICAL HISTORY FORM

*** When completed, send this form with the sample or fax it to the Lysosomal Diseases Testing Laboratory at 215-955-9554***

Dr. Name_____ Date_____

Address _____
for return _____ Dr. Tel #_____
of results _____ Dr. Fax #_____

Patient Name_____ Patient ID#_____

Age (DOB)_____ Sex_____ Race _____ Religion_____

Major complaint and history:

Birth and development:

Physical exam:

General appearance:

Eyes and ears:

Facial appearance (Hair, gums, skin, etc.):

Abdomen: Visceromegaly: Liver_____Spleen_____

Neurological:

Seizures _____ What type_____ Drugs _____

Tone and strength:

Cranial nerves: Reflexes:

Results of previous testing:

Bone marrow _____ CSF protein_____

EEG _____ EMG _____ Nerve conduction _____

X-rays _____ CT _____ MRI _____

Urine GAGs or oligosaccharides _____

Biopsies _____

Other tests (amino acids, organic acids, etc.) _____

BILLING REQUIREMENTS

**** When completed, send this form with the sample or fax it to the Lysosomal Diseases Testing Laboratory at 215-955-9554 ****

The Lysosomal Diseases Testing Laboratory at Jefferson Medical College of Thomas Jefferson University receives samples from around the world for diagnostic purposes. Very few laboratories have the qualifications or experience necessary to perform these studies. We must bill for our specialized services. Before we can proceed with testing on an individual, we require that precise billing information be provided with each sample. **NOTE: Due to the specialized nature of our testing and the fact that we are often out-of-state, we can not bill insurance companies**. We can either bill the institution sending us the sample or the patient or parents directly. Payments may be made in advance, and all checks can be made payable to **Jefferson Neurogenetics**. Visa and Mastercard are also acceptable forms of payment if the proper information is provided. Please complete the following billing information to accompany the sample.

Patient name _____DOB_____

MR#_____SS#_____

Referring Physician_____Tel#_____

If the **INSTITUTION** is to be invoiced provide the correct address and contact information here:

Referral Lab
New York Presbyterian Hospital
622 West 168th Street,
PH 3W, Room 355
New York, New York 10032
Tel: 212.305.6245 Fax: 212.342.3544

If the **PATIENT/FAMILY** is to be invoiced provide the correct address and contact information here:
(Upon payment, you will receive a receipt that can be forwarded to your insurance carrier for reimbursement)

If credit or debit card (Visa or Mastercard only) is to be used provide information here:

Type of card _____ Card Number_____

Name on card _____ Exp Date_____