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## REQUISITION FORM

|                             |                   |                      |                  |
|-----------------------------|-------------------|----------------------|------------------|
| Patient Name: (Last, First) |                   | Referring Physician: |                  |
| Patient ID #:               |                   | Clinic Name:         |                  |
| Date of Birth:              | Sex: F / M        | Clinic Address:      |                  |
| Patient Address:            |                   | Clinic Phone #:      |                  |
|                             |                   | Clinic Fax #:        |                  |
| Patient Phone #:            | Date Blood Drawn: | Time:                | Date Blood Sent: |

Payment (Check / Money Order/ Visa / Master Card / American Express) must accompany the specimen.

|   |
|---|
| <input type="checkbox"/> Check # _____ Amount \$ _____                                |
| <input type="checkbox"/> Credit Card # _____ Expiration Date _____<br>CVV Code: _____ |
| Name on Credit Card _____<br>Authorized Signature _____                               |

|                                      |   |  |   |
|--------------------------------------|---|--|---|
| <b>DIAGNOSIS</b>                     | <input type="checkbox"/> Recurrent Pregnancy Loss | <input type="checkbox"/> Endometriosis       | <input type="checkbox"/> <i>Pregnant (gestational age):</i>             |
| <input type="checkbox"/> IVF Failure | <input type="checkbox"/> Unexplained Infertility  | <input type="checkbox"/> <i>Non-Pregnant</i> | <input type="checkbox"/> Other (specify) _____<br>Diagnosis Code: _____ |

|               |  |                              |
|---------------|--|------------------------------|
| <b>PANELS</b> | <input type="checkbox"/> <b>IMPLANTATION FAILURE PANEL</b> (APA, ANA, ATA, ETA, IgG,M,A, | 3 red/tiger, 2 green         |
|               | <input type="checkbox"/> <b>NK PANEL</b> (RIPh, NKa)                                     | 2 green                      |
|               | <input type="checkbox"/> <b>PREGNANCY LOSS PANEL</b> (APA, ANA, ATA, LA, APTT, PT, ETA,  | 3 red/tiger, 2 green, 2 blue |
|               | <input type="checkbox"/> <b>PREGNANCY MONITORING PANEL</b> (APA, RIPh)                   | 1 red/tiger, 1 green         |

| CPT CODE                 |  |                               |
|--------------------------|--|-------------------------------|
| <input type="checkbox"/> | Activated Partial Thromboplastin Time (APTT) | 85730 1 blue                  |
| <input type="checkbox"/> | Anti-Nuclear Antibodies (ANA)                | 86225,86226,86235 1 red/tiger |
| <input type="checkbox"/> | Anti-Ovarian Antibodies (AOA)                | 86255 1 red/tiger             |
| <input type="checkbox"/> | Anti-Phospholipid Antibodies (APA)           | 86147,86148,83516 1 red/tiger |
| <input type="checkbox"/> | Anti-Thyroid Antibodies (ATA)                | 86376,86800 1 red/tiger       |
| <input type="checkbox"/> | Embryotoxicity Assay (ETA)                   | 89251 1 red/tiger             |
| <input type="checkbox"/> | HLA-DQ Alpha                                 | 86816 3 purple                |
| <input type="checkbox"/> | Immunoglobulin Panel (IgG,M,A)               | 86329 1 red/tiger             |
| <input type="checkbox"/> | Lupus Anticoagulant (LA)                     | 85613,58730 1 blue            |
| <input type="checkbox"/> | Lymphocyte Antibody Detection Assay (LAD)    | 86021 1 red F & 2 green M     |
| <input type="checkbox"/> | Natural Killer Cell Activation Assay (NKa) * | 88184, 88185x2,88187 1 green  |
| <input type="checkbox"/> | Prothrombin Time (PT)                        | 85610 1 blue                  |
| <input type="checkbox"/> | Reproductive Immunophenotype (RIPh)          | 88184, 88185x7,88187 1 green  |
| <input type="checkbox"/> | Sperm DNA Integrity Test (SDI)*              |                               |

\*Investigational Assay