BioSTAT
RAPID DIAGNOSTIC TESTING

Once form is complete please email to help@biostatdx.com

GENERAL CLINIC INFORAMTION	
Legal Name of Clinic:	Clinic Phone Number:
Clinic Address:	Clinic Fax Number:
Clinic State/ZIP:	Preferred Report Method ☐ Fax ☐ Web Portal ☐ Other*_____

OFFICE HOURS																			
Day	O	C	Day	O	C	Day	O	C	Day	O	C	Day	O	C	Day	O	C	Day	O	C
MON			TUE			WED			THR			FRI			SAT			SUN		

SPECIMEN PICK UP TIME(S)													
Day	Time	Day	Time	Day	Time	Day	Time	Day	Time	Day	Time	Day	Time
MON		TUE		WED		THUR		FRI		SAT		SUN	

PRIMARY CLINIC CONTACT INFORMATION for STAT Testing	
First & Last Name:	Title:
Phone Number:	Email Address:
COLLECTOR / PHLEBOTOMISTS FOR WEB PORTAL E-ORDER ENTRY	
First & Last Name:	Title:
Phone Number:	Email Address:

DOES THE CLINIC NEED THE FOLLOWING?

☐ Centrifuge ☐ Phleb Chair ☐ Refrigerator ☐ Lock Box* ☐ Phlebotomist ☐ Computer ☐ Printer

ORDERING PROVIDERS		
Provider Full Name:	Provider Title:	Provider NPI #
Signature		
Provider Full Name:	Provider Title:	Provider NPI #
Signature		
Provider Full Name:	Provider Title:	Provider NPI #
Signature		
Provider Full Name:	Provider Title:	Provider NPI #
Signature		

*Lock boxes are contingent on clinic being within a 75 mile radius of 4841 Keller Springs Rd Addison TX, 75001
*Selecting Other Report method may required approval or additional information.