HumanBiomics
by Envirobiomics.Inc

Envirobiomics, Inc.
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Chain of Custody Form

Job Number:
EBI code:

All samples must be paid via online order, phone, or invoice before results are released.
Please, fill this from legibly. Information on this page will be on results.

Date that sample was taken:

Compani Pay:
Customer Pay:
Paid Online:

PATIENT INFORMATION (REQUIRED)	PROVIDER INFORMATION (REQUIRED)
Last Name:	Provider Name:
First Name:	Facility Name:
Date of Birth (mmddyy):____/____/____	Address:
Gender: Male Female	Phone: Fax:
Specimen Collection Date (mmddyy):____/____/____	Email (for results):
Email:	NPI#:
Day-time Phone:	

Project Name / Customer Name:

TEST PANELS: (PLEASE CHOOSE)	Include:
Analysis 5 CIRS Biomarkers.	Human Complement C4a ELISA (Serum), Human MMP 9-ELISA (Serum) Human MSH ELISA (Plasma), Human TGF-beta 1 ELISA (Plasma), Human VEGF ELISA (Plasma).
Analysis 7 CIRS Biomarkers.	Human TGF-beta 1 ELISA (Plasma), Human MSH ELISA (Plasma), Human VEGF ELISA (Plasma), Human MMP 9-ELISA (Serum), Human Complement C4a ELISA (Serum), Human C3a desArg Fragment ELISA (Plasma), Human Leptin ELISA (Serum).
Analysis 9 CIRS Biomarkers.	Human TGF-beta 1 ELISA (Plasma), Human MSH ELISA (Plasma), Human VEGF ELISA (Plasma), Human MMP 9-ELISA (Serum), Human Complement C4a ELISA (Serum), Human C3a desArg Fragment ELISA (Plasma), Human Leptin ELISA (Serum), Human ADH (Antidiuretic Hormone) ELISA (Serum), Human Osmolality (Serum or Plasma).
HLA (MOLD / CIRS).	The Human Leukocyte Antigen (HLA) system comprises genes located on chromosome 6. These genes encode proteins found on cell surfaces, playing a crucial role in regulating the human immune system (Plasma).

For Internal use only

Recived By: Due Date: FM:

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PAYMENT:

A. Payment from: Healthcare provider Patient

B. Payment type: Check - Check #:_____ Please make checks payable to: Humanbiomics Laboratories (US Dollars only).

Credit card (**HumanBiomics Labs cannot accept HSA or Flexible Spending cards**)

Expiration date: _____ / _____

Credit Card #: . . .

I authorize HumanBiomics Laboratories, Inc. to charge my credit card above for the specified amount and test(s) selected on this form.

Cardholder Signature: Cardholder Printed Name:

Billing Address:

City: State: ZIP: Phone #:

Cardholder Email Address:

PATIENT / RESPONSIBLE PARTY ACKNOWLEDGEMENT:

Optional - Check this box if you give permission for HumanBiomics laboratories to retain your sample beyond 60 days after the completion of testing. By checking this box, you authorize us to retain your sample for test development, internal test validation, quality assurance, and training purposes. This option will have no impact on the processing, testing or results of your sample.

I, (patient name), consent to having a sample specimen collected for the purpose of genetic testing by HumanBiomics laboratories. I understand that i may seek independent advice from other health care professionals, such as a genetic counselor, prior to giving consent. Furthermore, I understand that the physical risk involved with sample collection is minimal and that HumanBiomics laboratories disclaims responsibility and shall not be held liable for any damage incurred. I also consent to the disclosure of results only to myself and the party designated in the "Healthcare Provider Information" section of this requisition form. I acknowledge that the laboratory has not asked me to discontinue treatment or care from my healthcare provider

Signature: Date:

If Applicable Guardian Signature: Date:

Guardian Name: Relationship to Patient:

Important Notes to Patient and Physician

1.- The genetic tests examine your DNA to determine your "genotypes" for risk assessment for different associated diseases or conditions.
2.- Further information about the specific tests being ordered, including a general description of the tests and of associated diseases or conditions, is available through your health care provider or through the HumanBiomics website, https://humanbiomics.com.
3.- Before giving consent, you may wish to seek professional genetic counseling.
4.- Your sample will only be used for the genetic testing authorized by your consent and will be destroyed within 60 days of test completion unless otherwise indicated above.
5.- A positive test result serves as a predictor, or indication, that you may be predisposed or bear an increased risk for a specific disease or condition. However, no numerical level of certainty has been established for these tests.
6.- A positive result is an indication, not a certainty, that you may be predisposed or bear an increased risk for a specific disease or condition. Therefore, we encourage you to consider further independent testing, as well as checking with your physician and/or seeking professional genetic counseling.
7.- To maintain confidentiality, the results will only be released to yourself and any individuals you designate with your written consent on the requisition form.