NEW YORK STATE DEPARTMENT OF HEALTH
WADSWORTH CENTER
CLINICAL LABORATORY EVALUATION PROGRAM
EMPIRE STATE PLAZA, PO BOX 509
ALBANY, NY 12201-0509

NEW YORK STATE NON-PERMITTED LABORATORY TEST REQUEST APPROVAL FORM

(Please type or print neatly.)

Justification for requesting use of a facility without a NYS Permit must be provided in the space below:

Today's Date: _____

Patient Name: _____

Patient Identifier/#: _____

Symptoms/Dx: _____

_____

Gene Name (if applicable): _____

_____

Test Requested: _____

_____

Specimen Type: _____

INFORMATION FOR FACILITY MAKING REQUEST/SENDING SPECIMEN:

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Person at Facility: _____

Phone Number: _____ Fax Number: _____

PFI#: ___ ___ ___ ___ **OR** CLIA#: _____ _____

Ordering Physician's Name: _____

Please ensure all information is provided as incomplete forms will not be processed and delay permission for referral.

INFORMATION FOR LABORATORY PERFORMING TESTING:

Name of Laboratory Director: _____

Name of Laboratory or Institution: _____

Address: _____

_____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

CLIA #: _____ NYS PFI#: ___ ___ ___ ___ (If applicable)

Genetic Tests to:
Genetic Testing Quality Assurance Program
Wadsworth Center, NYSDOH
Ph: (518) 474-6271

Fax: (518) 486-2693

Cytogenetic Tests to:
Cytogenetics Quality Assurance Program
Wadsworth Center, NYSDOH
Ph: (518) 474-6796

Fax: (518) 486-4921

All others to:
Clinical Laboratory Evaluation Program
Wadsworth Center, NYSDOH
Ph: (518) 485-5378

Fax: (518) 449-6917

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