Promarker®D

Test Requisition Form

ALL SECTIONS MUST BE COMPLETED

PATIENT INFORMATION

Last Name

First Name

Sex ☐ Female ☐ Male

Date of Birth (mm/dd/yyyy)

Medical Record #

Street Address

City State ZIP

Phone #

Email

ACCOUNT INFORMATION

Practice Name

Street Address

City State ZIP

Phone #

Secure Fax #

Email

Ordering Physician

NPI #

Copy Reports To

PATIENT SIGNATURE FOR INFORMED CONSENT & FINANCIAL RESPONSIBILITY

I accept full financial responsibility for any payment obligation associated with my test and consent to the selected test being performed.

X _____

Patient Signature Date (mm/dd/yyyy)

AUTHORIZED SIGNATURE

X _____

Ordering Physician Signature Date (mm/dd/yyyy)

PAYMENT

This test is currently available as a self-pay option only.

Please refer to the Patient Information Sheet for available payment options.

Note: Payment must be completed prior to the blood draw at a participating service provider.

TEST & SPECIMEN INFORMATION

Promarker®D Test

Specimen Type
1. Plasma 1x 4ml K2EDTA tube
2. Serum 1x 5ml SST tube

Affix Patient ID label to this form & label both tubes with date of birth of patient

Collection Date (mm/dd/yyyy)

Collection Time (hh:mm) ☐ AM ☐ PM

Service Provider ☐ Client Bill

INTENDED USE & CLINICAL INFORMATION

Promarker®D is intended for assessing the risk of developing diabetes-related chronic kidney disease (DKD) in the next four years in people with type 2 diabetes (T2D). The Promarker®D test generates a prognostic risk score for DKD by combining measurements of two protein biomarkers with two clinical variables (age and eGFR) using a proprietary algorithm.

Promarker®D is indicated for adults aged 18 and over with T2D and normal to moderately decreased kidney function. The test is designed to be performed by trained laboratory personnel, with test results to be used by healthcare professionals to support clinical decision-making and improve individual outcomes.