

BLOCK REQUEST FORM



To: _____ Requesting Facility: _____
Fax: _____ Requesting Physician: _____
Phone: _____ Phone: _____
Date: _____

Patient Name

DOB

Specimen #

Collection date

Material requested

Reason for request

Physician Signature

Patient Signature

**Please send block(s) to:
CombiMatrix
310 Goddard, Suite 150
Irvine, CA 92618
FedEx Account # 3215-22-289**

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CombiMatrix | 310 Goddard Suite 150, Irvine, CA 92618 | T 800.710.0624 | Fax 949.753.4725 | www.combimatrix.com