

**\*\*Send top copy with swab sample, retain duplicate copy\*\***

Please complete this **ENTIRE ORDER FORM**.  
Any incomplete or illegible information may result in delayed results.

Sample Type: Cheek Swab    Test: Alpha-1 Panel

**Collection Date (REQUIRED)** MM-DD-YYYY:

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**Patient Information (REQUIRED - PLEASE PRINT)**

Birth Sex: ☐ Male ☐ Female

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

**Date of Birth (REQUIRED)** MM-DD-YYYY:

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Patient History: (Check all that apply)

☐ COPD    ☐ Emphysema    ☐ Asthma    ☐ Liver Disease

Family History: (Check all that apply)

☐ COPD    ☐ Emphysema    ☐ AATD    ☐ Liver Disease

**Patient Consent (REQUIRED)**

By signing this form, I confirm that: (i) I have read, or had read to me, the AlphaDetect Patient Information Overview and understand the information provided about Alpha-1 testing; (ii) I have had the chance to ask questions & have received answers; (iii) By signing, I give permission for AlphaDetect to perform the ordered testing; (iv) My test results & health information may be de-identified, indefinitely retained, and used for research purposes to further learn about Alpha-1 antitrypsin deficiency; (v) Free resources, genetic counseling, and support are available through the Alpha-1 Foundation. If I am identified at risk, I provide my permission and email address below for the Alpha-1 Foundation to contact me about these valuable resources.

**Patient Signature: (REQUIRED)**

\_\_\_\_\_

**Patient Email:**

\_\_\_\_\_

☐ Do not use my de-identified sample for research purposes to help others

**Healthcare Provider Information (REQUIRED - PLEASE PRINT)**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**National Provider Identifier (NPI #)**

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Results will automatically be sent via fax

To access your results online, please visit [www.alphadetect.org/results](http://www.alphadetect.org/results)

I attest that the patient has been informed about the purpose and limitations of the test and use of their health information. I certify that I am authorized to order this test (or was delegated authority by an authorized ordering healthcare provider) and the test result will be used in the patient's care.

**Provider Signature:** \_\_\_\_\_

LOT 6731226

Alpha Detect 2 Part Card  
Job # 6731226-011  
08-06-26  
First Proof

**CUSTOMER**

APPROVED ☐

NOT APPROVED ☐

SIGNATURE

NAME:

DATE:

EBF

REF. 105XXXXX

REV. AA

DATE:

SIGNATURE

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VO Perf  
Does Not Print  
Glue Line Between Parts 1 & 2  
Indicated in Green  
Does Not Print

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**Patient Email:**

\_\_\_\_\_

☐ Do not use my de-identified sample for research purposes to help others

**Healthcare Provider Information (REQUIRED - PLEASE PRINT)**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**National Provider Identifier (NPI #)**

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REF. 105XXXXX

REV. AA

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