# CYSTINURIA MANAGEMENT PROGRAM ENROLLMENT FORM
## 24-HOUR CYSTINE URINE TEST REQUEST

### Patient information

LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH GENDER (M/F)

MEDICAL RECORD # (MRN) HEIGHT (inches) WEIGHT (pounds)

STREET ADDRESS

CITY STATE ZIP CODE

HOME PHONE # MOBILE PHONE #

EMAIL

CURRENTLY ON THIOL-BINDING MEDICATION: ☐ YES ☐ NO

IF YES, WHICH MEDICATION? ____________________

**ALL PATIENT INFORMATION ABOVE MUST BE COMPLETED.**

### Practitioner information

LAST NAME FIRST NAME

FACILITY NAME

STREET ADDRESS

CITY STATE ZIP CODE

OFFICE/PRACTITIONER PHONE # FAX #

PRACTITIONER NPI # OFFICE CONTACT NAME

PRACTITIONER EMAIL

**ALL PRACTITIONER INFORMATION ABOVE MUST BE COMPLETED.**

### Order

**Diagnosis:** ☐ E72.01 CYSTINURIA ☐ OTHER ____________________

**Diagnosis in ICD-CM format in effect at date of service (highest specificity required)**

**24-hour cystine urine panels** *(for patients with known cystinuria)*

| TESTS | | |
|---|---|---|
| Cystine concentration | Urine pH | Urine Sodium |
| Timed collection | Urine volume | Urine Nitrogen |
| Quantitative cystine | Urine Calcium | Creatinine |

**ALL TESTS WILL BE PERFORMED ON EACH 24-HOUR URINE COLLECTION.**

Testing will be performed by Select Reference Laboratories, LLC.

TEST FREQUENCY INSTRUCTIONS, SEND COLLECTION KIT TO PATIENT EVERY:

☐ 3 MONTHS* ☐ 4 MONTHS* ☐ 6 MONTHS* ☐ 12 MONTHS* ☐ HOLD SHIPMENT OF TEST UNTIL: _______/_______/_____________

Prescriber Direction:____________________

*In a 12-month period.

For questions regarding this program,
contact the Cystinuria Management Program at:

1-855-846-5390, M-F: 8:00AM-8:00 PM (ET)

**SUBMIT THIS COMPLETED FORM:**
**Via Fax: 1-844-889-2577**
**Via Email: info@ManagingCystinuria.com**

All orders will be processed next business day.

**Criteria for free testing:**

Patient has been diagnosed with cystinuria.

I hereby attest that the patient has been diagnosed with cystinuria and is a candidate for this 24-Hour Cystine UrineTest. I understand that the diagnostic testing services offered under this program are directional in nature and that they do not eliminate the need for additional medical management.

Authorized practitioner signature Date

Program may be cancelled or changed at any time.

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