

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**