



47768402603151921

Requisition Form Quest

Account#:11971475		Collection Date and Time:03/15/2026 19:21	
Req/Control#:47768402603151921		Courtesy Copy: Fax# Fax(Attn):	
Bill Type:Third Party		Courtesy Account# Courtesy Accnt(Attn):	
Client/Ordering Site:BioGeneX L.L.C.		Ordering Provider:DiMartino,Dwight	
Address:51 E Main St		NPI:1386340859	
City, State Zip:Avon,CT 06001		UPIN:	
Phone:959-204-5375 Fax:18008648621		Physician ID:	
Patient Name: [REDACTED]		Patient SSN :	
Date of Birth:10/07/2000 Gender:Male Age:		Patient ID:4776840 Alt ID:	
Patient Address:		Phone:0000000000	
City, State, Zip:		Alt Control #:	
Tests Ordered			
6399 CBC (INCLUDES DIFF/PLT) 899 TSH 34429 T3, FREE 866 T4, FREE 15983 TESTOSTERONE, TOTAL, MS 18944 TESTOSTERONE, FREE 30740 SEX HORMONE BINDING GLOBULIN 90567 DIHYDROTESTOSTERONE 402 DHEA SULFATE 31493 PREGNENOLONE, LC/MS/MS 90963 T3 REVERSE, LC/MS/MS 30289 ESTRADIOL, ULTRASENSITIVE LC/MS/MS 10231 COMPREHENSIVE METABOLIC PANEL			
Order Priority: R [Routine]			
Clinical Information:			
Diagnosis Information			
R68.82 R86.1 R53.82 E34.9 E28.1 E28.0 R94.6 Z51.81			
Responsible Party/Guarantor Information:		Parent/Guardian Information:	
Name: [REDACTED]		Name: ,	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Phone:0000000000 Relation to Patient:Self		Phone:	
Primary Insurance		Secondary Insurance	
Lab Ins Code:		Lab Ins Code:	
Ins Co Name:		Ins Co Name:	
Ins Address 1:		Ins Address 1:	
Ins Address 2:		Ins Address 2:	
Ins City, State Zip:		Ins City, State Zip:	
Policy Number:		Policy Number:	
Group #:		Group #:	
Emp/Group Name:		Emp/Group Name:	
Provider #:		Provider #:	
Primary Policy Holder / Insured		Secondary Policy Holder / Insured	
Insured Name:Opti,Test		Insured Name: ,	
Insured Address:		Insured Address:	
Insured Relation to Pt:Self		Insured Relation to Pt:	
ABN:		Worker's Comp: Date of Injury:	

Electronically Signed By Dwight DiMartino, APRN FNP-C 03/15/2026