

THE JOHNS HOPKINS UNIVERSITY
DACI Reference Laboratory
HOUSE DUST ANALYSIS PHYSICIAN REQUEST FORM

DATE ____/____/____ PLEASE PRINT ALL INFORMATION

PHYSICIAN NAME & ADDRESS _____

TELEPHONE ____/____/____ FAX ____/____/____

DIAGNOSIS (ICD-9) CODE _____

PATIENT'S NAME & ADDRESS _____ DOB: _____

TELEPHONE ____/____/____ FAX ____/____/____

PHYSICIAN: Please indicate tests:

- | | |
|--|--|
| <input type="checkbox"/> Dust Mite (Der p 1) @ \$30 | <input type="checkbox"/> Cockroach (Bla g) @ \$30 |
| <input type="checkbox"/> Dust Mite (Der f 1) @ \$30 | <input type="checkbox"/> Cockroach (Bla g 11) @ \$30 |
| <input type="checkbox"/> Cat (Fel d 1) @ \$30 | <input type="checkbox"/> Mouse Urinary Prot (Mus m 1) @ \$30 |
| <input type="checkbox"/> Dog (Can f 1) @ \$30 | <input type="checkbox"/> Mold Spore Colony Count @ \$30
(not speciated) |
| <input type="checkbox"/> Rat Urinary Prot (Rat n 1) @ \$30 | |

General Household Survey Specific location(s): _____

DUST COLLECTOR FEE: \$12 (additional collector is \$4.00 if vacuuming more than one area)

TOTAL NUMBER OF TESTS: _____ @ \$30.00 per test per area = \$ _____

a. FIRST COLLECTOR @ \$12 = _____

b. ADDITIONAL COLLECTORS (#) _____ @ \$4.00 = _____

TOTAL AMOUNT DUE..... \$ _____

ADD a. & b. AND ENTER AMOUNT HERE..... - _____
(pay this amount by check or creditcard authorization)

BALANCE DUE (Please submit this fee when you return your dust to us. Explanation is enclosed with your dust packet.) \$ _____

PHYSICIAN'S SIGNATURE _____

INSTRUCTIONS FOR PROCESSING ON REVERSE SIDE

(See page 2)

PATIENT: Please send this order form with check or creditcard authorization for the collector (fee non-refundable).

SEND TO: **JOHNS HOPKINS UNIVERSITY**
 DACI Reference Laboratory
 PO Box 26037
 BALTIMORE, MD 21224

For faster service, you may use your creditcard and call the laboratory toll-free at **800/344-3224** Monday thru Friday from 8:30 a.m. to 5 p.m. Dust collector packet will be mailed to you.

When dust collector is returned to the laboratory for analysis, please remit payment of \$30.00 per test per area. Report and interpretation will be sent to your physician within 3 weeks of receipt of vacuumed dust sample. Please call us if you have any questions.

PLEASE SELECT ONE:

Check enclosed for \$ _____

Creditcard authorization:

VISA Mastercard American Express DISCOVER

Creditcard number _____ Expiration Date ___ / ___ / ___

Cardholder's name and address:

Signature of cardholder _____