

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 ____/____/____

TEST: ____ Mold Spore Colony Count @ \$30

Area: ____ General Household Survey ____ Specific location(s): _____

DUST COLLECTOR FEE: \$12 (additional collector is \$6.50 if vacuuming more than one area)

a. FIRST COLLECTOR @ \$12 = \$ 12.00
b. ADDITIONAL COLLECTORS (#) ____ @ \$6.50 = \$ _____
Total \$ _____

AMOUNT PAID FOR COLLECTOR(S)..... - _____

TOTAL NUMBER OF TESTS: ____ 1 ____ @ \$30.00 per test per area = \$ 30.00

BALANCE DUE FOR TESTING- \$ 30.00
(Please submit this fee by check or credit card with your dust specimen.)

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 _____

INSTRUCTIONS FOR PROCESSING ON

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.