

# CABOTEGRAVIR REQUISITION

## **Columbia University Irving Medical Center**

Clinical Pharmacology and Toxicology Laboratory  
630 West 168<sup>th</sup> Street, VP&S 11-401B  
New York, NY 10032

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PFI: 8006  
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### **PLEASE TYPE/PRINT**

**Patient Name** (Last Name, First Name): \_\_\_\_\_

**Patient Date of Birth** (MM-DD-YYYY): \_\_\_\_\_

**Patient Gender:** \_\_\_\_\_

**Sample Collection Date and Time:** \_\_\_\_\_

**Hospital/Institution Name:** \_\_\_\_\_

**Healthcare Provider Name:** \_\_\_\_\_

**Healthcare Provider Signature:** \_\_\_\_\_

**Healthcare Provider E-mail or Fax:** \_\_\_\_\_  
(Required for results reporting)

### **For Laboratory Use Only:**

Date and time specimen receipt: \_\_\_\_\_

Accession number: \_\_\_\_\_