# SERUM INSULIN-LIKE GROWTH FACTOR 1 (IGF-1) REQUISITION

**Columbia University Irving Medical Center**
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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: _____

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