The Johns Hopkins Hospital
Department of Pathology

Account #

____
Office Use Only

Application for Account Number

Instructions: Please provide complete information in each section (I-VIIIA). Please return the completed form to The Johns Hopkins Hospital, Department of Pathology. Carnegie 423, 600 N. Wolfe St., Baltimore, MD 21287 Attn: Danyelle Parrish. Phone: (410) 502-4360/Fax (410) 955-5961. **Please print**

Section I. Name or Title of project: **IRB #:** ___________________

____

____ **Est. Start Date:** ______________

Section II. Investigator/account holder information: (Ordering physician). Please use complete address

Name: ____ **MD#:** ______________

Address: ____ **Phone:** ______________

____ **Pager:** ______________

Facility (circle)**: JHH JHU Outside:** _____________ **Fax:** ______________

Section III. Sample Information: ___Human (Identified)

___Human (Deidentified) ___Non-Human (specify)________________ *(Complete Supplemental Form)**

What clinic will samples be drawn in? _____________ **Do you have Epic Support? (i.e. Label Printer)** Yes/No

For the following, please Circle the Appropriate Option:

Sample Matrix: ___CSF ___Urine ___Serum ___Plasma ___Other (specify) ____________**?**

Will specimens arrive batched? Yes/No *****If yes, complete Supplemental Form**

Section IV. Test Required: Use additional paper if needed.

Soft ID Code	Test Name	Charge Quoted price	Responsible Lab Area (Internal Use Only)

Section V. Report Panic Values to: (will show as the pager # on requisition) **Phone/**

Contact Person: ____ **Pager:** _____________________

Section VI. Results: Do you want results of this study sent to EPIC? Yes / No

***If you answered No, do you want results faxed? Yes / No**

Fax #: ______________________

***A Fax Verification form will be faxed**

Section VII. Billing Statements: Mail to the following address: **SAP Budget #**_____________________

Name: ____ **Email:** __________________________

Address: ____ **Phone:** __________________________

____

Section VIII. Approval signatures:

A. Investigator/Account holder: _______________________________________ **Date:** _____________

B. Pathology Administration: _______________________________________ **Date:** _____________

OFFICE USE ONLY

Loc File: ____ **Client SU:** ____ **Client EFS:** ____ **Autofax: Y N Depot:** _____ **Inst:** _____

Fax Verification Form: Y N JHMCIS: Y N AP Review/Setup: ____/____ **Paper Format:**________

____