

**THIS IS NOT A TEST REQUEST FORM. PLEASE COMPLETE AND SUBMIT
WITH THE TEST REQUEST FORM OR ELECTRONIC PACKING LIST.**

**CLINICAL INFORMATION FOR PEMGUS PEMPHIGOLD
ANTIBODY PANEL (ARUP 0092001)**

PLEASE PRINT

Patient's Name: _____

Specimen collection date: _____ / _____ / _____

Presumptive diagnosis/reason for testing:

_____ Initial diagnosis Monitoring

Alternate/additional disease consideration: _____

Name of clinical contact (to discuss atypical or clinically relevant test findings):

Clinical contact phone number: (_____) _____

Additional clinical information that may be helpful in interpreting results (not required):

