

## Diagnostic Request Form

### 1) Practitioner Details

Name: _____
Qualification: _____
Address: _____ _____ _____
Phone: _____
Email: _____

### 2) Patient Details

Name: _____
Sex: M / F                      Date of Birth: _____
Address: _____ _____
Email: _____
Phone: _____

### 3) Charge to: (Select one)

- Practitioners account, Signature Required: \_\_\_\_\_
- Internet Payment to account number: 06 0101 0896694 00                      Reference (customer name/diagnostic)
- Patient Credit Card: No.: \_\_\_\_\_ Exp: \_\_\_\_\_ NOTE: 1.6% surcharge applies.

### 4) Tests requested:

#### **Intestinal Permeability**

Urine Test for Mannitol, Lactulose and the Mannitol:Lactulose ratio  
Six hour urine collection  
RRP\$230.00

**5) Time the Mannitol and Lactulose liquid was ingested:** \_\_\_\_\_

**6) Time the Urine Collection finished:** \_\_\_\_\_

**7) Volume of Urine Collected:** \_\_\_\_\_ mL

Optional Additional Information							
Current Medications (please tick)				Last Dose taken:			
<input type="checkbox"/>	Estrogen	<input type="checkbox"/>	Cortisol	<input type="checkbox"/>	Melatonin	<input type="checkbox"/>	DIM
<input type="checkbox"/>	Progesterone	<input type="checkbox"/>	DHEA	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	Pregenolone
<input type="checkbox"/>	Testosterone	<input type="checkbox"/>	DHT	<input type="checkbox"/>	Arimidex	<input type="checkbox"/>	Growth Hormone
<input type="checkbox"/>	Indole-3-Carbinol						
<b>Notes</b>							
Type of Medication (please tick)							
<input type="checkbox"/>	Cream	<input type="checkbox"/>	Capsule	<input type="checkbox"/>	Tablet	<input type="checkbox"/>	Troche
<input type="checkbox"/>	Pessary	<input type="checkbox"/>	Suppository	<input type="checkbox"/>	Injection	<input type="checkbox"/>	
<b>Notes</b>							
Current Symptoms							
<input type="checkbox"/>	Hot Flushes	<input type="checkbox"/>	Poor Erections	<input type="checkbox"/>	Joint Stiffness	<input type="checkbox"/>	Low Stress Resistance
<input type="checkbox"/>	Low Sex Drive	<input type="checkbox"/>	Tired in the morning	<input type="checkbox"/>	Tired all day	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	Cold Hands/Feet	<input type="checkbox"/>	Poor Memory	<input type="checkbox"/>	Dry Vagina	<input type="checkbox"/>	Sore Breasts
<input type="checkbox"/>	Weak Strength	<input type="checkbox"/>	Emotional	<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	Weight Loss
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Fluid Retention	<input type="checkbox"/>	Poor Sleep	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	PMT	<input type="checkbox"/>	Weight gain				
<b>Notes</b>							