# 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:

### Kryptopyrroles

Urine Test of Kryptopyrroles
Afternoon void
RRP$240.00

**Optional Additional Information**

  

| **Current Medications** (please tick) | | | Last Dose taken: | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Estrogen | ☐ | Cortisol | ☐ | Melatonin | ☐ | DIM |
| ☐ | Progesterone | ☐ | DHEA | ☐ | Thyroid | ☐ | Pregenolone |
| ☐ | Testosterone | ☐ | DHT | ☐ | Arimidex | ☐ | Growth Hormone |
| ☐ | Indole-3-Carbinol | | | | | | |

**Notes**

| **Type of Medication** (please tick) | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Cream | ☐ | Capsule | ☐ | Tablet | ☐ | Troche |
| ☐ | Pessary | ☐ | Suppository | ☐ | Injection | ☐ | |

**Notes**

| **Current Symptoms** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Hot Flushes | ☐ | Poor Erections | ☐ | Joint Stiffness | ☐ | Low Stress Resistance |
| ☐ | Low Sex Drive | ☐ | Tired in the morning | ☐ | Tired all day | ☐ | Low Blood Pressure |
| ☐ | Cold Hands/Feet | ☐ | Poor Memory | ☐ | Dry Vagina | ☐ | Sore Breasts |
| ☐ | Weak Strength | ☐ | Emotional | ☐ | Hair Loss | ☐ | Weight Loss |
| ☐ | Allergies | ☐ | Fluid Retention | ☐ | Poor Sleep | ☐ | Headaches |
| ☐ | PMT | ☐ | Weight gain | | | | |

**Notes**

  