

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: Select from the following tests:

Comprehensive Digestive Stool Analysis: please note that 8 new panels are now available.

- CDSA Level 1:** Tests for Macroscopy, Microscopy, Bacteriology, Fungal and Parasitology
RRP \$217.50
- CDSA Level 2:** Macroscopy, Microscopy, Digestion, Absorption, Metabolism, Bacteriology, Fungal and Parasitology
RRP \$365.00
- CDSA Level 3:** Macroscopy, Microscopy, Digestion, Absorption, Metabolism, Bacteriology, Fungal, Parasitology and sensitivities
RRP\$ 440.00
- CDSA Level 3+:** Macroscopy, Microscopy, Digestion, Absorption, Metabolism, Bacteriology, Fungal, Parasitology, inflammation, tumour/ulcer and sensitivities
RRP\$ 575.00
- CDSA Level 4:** Macroscopy, Microscopy, Digestion, Absorption, Metabolism, Bacteriology, Fungal, Parasitology, Parasitology EIA and sensitivities
RRP \$ 537.00
- CDSA Level 4+:** Macroscopy, Microscopy, Digestion, Absorption, Metabolism, Bacteriology, Fungal, Inflammation, tumour/ulcer, Parasitology, Parasitology EIA and sensitivities
RRP\$ 672.00
- CDSA Level 5:** Macroscopy, Microscopy, Bacteriology, Fungal, Parasitology, Parasitology EIA and sensitivities
RRP\$ 365.00

Optional Additional Information							
Current Medication (please tick)							
<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						
Notes							
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"/>	
Notes							
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				
Notes							