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:

myDNA Comprehensive Health Report
Morning Buccal swabs
RRP$475.00

5) Sample Collected:

Date:

Time:

Unique Patient Identifier (on the vial):

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

