

Understanding the Test Requisition

Below is an example of our Test Requisition form. It asks important questions about patient health and well-being. Please encourage your patients to complete all sections on both sides of the form.

SIDE A

Section 1

Individual Information: name, address, phone, gender, date of birth etc.

Section 2

Current Menstrual Status (women): this is important for determination of the appropriate expected hormonal range.

Section 3

Symptoms: reported by patient. Symptom severity is key to evaluating patient hormonal health. A rating of 0 = none, 1 = mild, 2 = moderate, 3 = severe is reported in bar graph form on page two of the test report. This allows correlation of tested hormone levels with reported symptoms, thus providing a more comprehensive evaluation.

Section 3a

Basal Body Temperature: basal body temperature is optional and only requested when evaluating thyroid dysfunction.

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Test Requisition

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Beaverton, OR 97008
Phone: 503-466-2445 Fax: 503-466-1636
info@zrtlab.com www.zrtlab.com

1 Individual Information Please print clearly, placing one capital letter in each cup. This will help us process your evaluation quickly.

First Name: _____ MI: _____
 Last Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Day Phone: _____ Evening Phone: _____
 Email: _____
 Gender: Female Male Birth Date: / / Height: / / Weight: / / Waist Size: / /

2 Current Menstrual Status - (Women Only)

First day of last menses: / / Hysterectomy: No Yes Year / /
 Regular Cycles: Yes No Ovaries Removed: No One Both Year / /
 Irregular Cycles: Yes No Currently Pregnant: No Yes # of Months _____
 No Menstrual Cycles: Yes No

3 Symptoms Please use the symptoms for your gender. Indicate the symptoms you are experiencing as: 0 (none), 1 (mild), 2 (moderate), or 3 (severe). For example, if you are moderately stressed you would indicate this by darkening the 2 next to 'Stress':

For Women	
Hot Flashes <input type="checkbox"/> Foggy Thinking <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Aches and Pains <input type="checkbox"/> Allergies <input type="checkbox"/> Sugar Craving <input type="checkbox"/> Loss Scalp Hair <input type="checkbox"/> Tender Breasts <input type="checkbox"/> Anxious <input type="checkbox"/> Weight Gain - Hips <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hair Dry or Brittle <input type="checkbox"/> Constipation <input type="checkbox"/> Hoarseness <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/>	Night Sweats <input type="checkbox"/> Memory Loss <input type="checkbox"/> Bone Loss <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Sensitivity To Chemicals <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Increased Facial or Body Hair <input type="checkbox"/> Bleeding Changes <input type="checkbox"/> Water Retention <input type="checkbox"/> Decreased Stamina <input type="checkbox"/> Swelling or Puffy Eyes/Face <input type="checkbox"/> Nails Breaking or Brittle <input type="checkbox"/> Rapid Heartbeat <input type="checkbox"/> Increased Urinary Urges <input type="checkbox"/> Numbness - Feet or Hands <input type="checkbox"/>
Vaginal Dryness <input type="checkbox"/> Tired <input type="checkbox"/> Sleep Disturbed <input type="checkbox"/> Morning Fatigue <input type="checkbox"/> Stress <input type="checkbox"/> Weight Gain - Waist <input type="checkbox"/> Acne <input type="checkbox"/> Nervous <input type="checkbox"/> Fibrocystic Breasts <input type="checkbox"/> Decreased Muscle Size <input type="checkbox"/> Slow Pulse Rate <input type="checkbox"/> Thinning Skin <input type="checkbox"/> Infertility Problems <input type="checkbox"/> Healing Slow <input type="checkbox"/> Low Blood Sugar <input type="checkbox"/> Breast Cancer <input type="checkbox"/>	Incontinence <input type="checkbox"/> Depressed <input type="checkbox"/> Evening Fatigue <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Decreased Libido <input type="checkbox"/> Mood Swings <input type="checkbox"/> Irritable <input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Rapid Aging <input type="checkbox"/> Decreased Sweating <input type="checkbox"/> Intensity Problems <input type="checkbox"/> Gout <input type="checkbox"/> High Blood Pressure <input type="checkbox"/>
For Men	
Burned Out Feeling <input type="checkbox"/> Decreased Mental Sharpness <input type="checkbox"/> Nervous <input type="checkbox"/> Decreased Stamina <input type="checkbox"/> Decreased Flexibility <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Headaches <input type="checkbox"/> Sensitivity To Chemicals <input type="checkbox"/> Decreased Urine Flow <input type="checkbox"/> Bitter Taste <input type="checkbox"/> Swelling or Puffy Eyes/Face <input type="checkbox"/> Nails Breaking or Brittle <input type="checkbox"/> Rapid Heartbeat <input type="checkbox"/> Low Blood Sugar <input type="checkbox"/> Oily Skin or Hair <input type="checkbox"/>	Anorexia <input type="checkbox"/> Decreased Muscle Size <input type="checkbox"/> Neck or Back Pain <input type="checkbox"/> Sugar Craving <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Decreased Erections <input type="checkbox"/> Increased Urinary Urges <input type="checkbox"/> Stress <input type="checkbox"/> Slow Pulse Rate <input type="checkbox"/> Thinning Skin <input type="checkbox"/> Hearing Loss <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Acne <input type="checkbox"/>
Difficulty Sleeping <input type="checkbox"/> Mental Fatigue <input type="checkbox"/> Morning Fatigue <input type="checkbox"/> Weight Gain - Waist <input type="checkbox"/> Size Muscles <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Decreased Libido <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Rapid Aging <input type="checkbox"/> Decreased Sweating <input type="checkbox"/> Infertility Problems <input type="checkbox"/> Gout <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Aggressive Behavior <input type="checkbox"/>	Increased Forgetfulness <input type="checkbox"/> Irritable <input type="checkbox"/> Evening Fatigue <input type="checkbox"/> Weight Gain - Waist <input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Allergies <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Night Sweats <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hair Dry or Brittle <input type="checkbox"/> Constipation <input type="checkbox"/> Hoarseness <input type="checkbox"/> Numbness - Feet or Hands <input type="checkbox"/> Prostate Cancer <input type="checkbox"/>

3a Basal Body Temperature and Hours Fasting

Day 1: _____ Day 2: _____ Day 3: _____ Hours Fasting: _____

Please continue on the other side.
(we need just a little more information and your signature too.)

3a

SIDE B

Section 4

Hormone/Medication Use: prescribed dosage, and exact time of last dose are extremely important for accurate evaluation of test results.

Section 5

Sample Collection Date and Time: indicate the date(s) and time(s) that each sample was collected.

Section 6

Panels and Tests: indicate the individual hormone(s) and/or panel(s) to be tested by checking the appropriate box(es).

Section 7

Payment: indicates the Payment Option that you have chosen.

Section 8

Client Signature: for authorization and/or consent for laboratory testing.

Section 9

Health Provider Information: your name and address will print here.

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Hormone/Medication Use

0400 0002
J504B4C

Hormone Type	Brand	Delivery	Dosage	Date	Time	Times Per Day	How Long Used
Example: Progesterone	XXZ Cream	Topical	25 mg	mm/dd/yy	8:30 pm	0	days

Also list other medications or herbal supplements taken regularly.

5 Sample Collection Date and Times

Saliva Collection Date: / / Blood Spot Collection Date: / /
 Morning: _____ Noon: _____ Evening: _____ Night: _____
 Time: _____

6 Panels and Tests Please fill the oval for the panel(s) or individual test(s). If you select individual tests in addition to panels, please do not duplicate tests that are in a panel you have already selected. * Estrone and Estradiol are currently not offered to New York residents

<input type="checkbox"/> Comprehensive Female Profile I <input type="checkbox"/> Comprehensive Female Profile II <input type="checkbox"/> Comprehensive Male Profile I <input type="checkbox"/> Comprehensive Male Profile II	Saliva: E2, Pg, T, DS, Cx4 Blood Spot: FT4, FT3, TSH, TPO Saliva: Cx4 Blood Spot: E2, Pg, T, DS, SHBG, FT4, FT3, TSH, TPO Saliva: E2, T, DS, Cx4 Blood Spot: PSA, FT4, FT3, TSH, TPO Saliva: Cx4 Blood Spot: E2, T, DS, SHBG, PSA, FT4, FT3, TSH, TPO	Female/Male Saliva Profile I: E2, Pg, T, DS, C Female/Male Saliva Profile II: E2, Pg, T, DS, Cx2 Female/Male Saliva Profile III: E2, Pg, T, DS, Cx4 Adrenal Stress Profile: DS, Cx4 Diurnal Cortisol: Cx4	CardioMetabolic Profile: IN, hsCRP, HbA1c, TG, CH, HDL Essential Thyroid Profile: FT4, FT3, TSH, TPO Female Blood Profile I: E2, Pg, T, DS, C, SHBG Female Blood Profile II: E2, Pg, T, DS, C, SHBG, FT4, FT3, TSH, TPO Male Blood Profile I: E2, T, DS, C, SHBG, PSA Male Blood Profile II: E2, T, DS, C, SHBG, PSA, FT4, FT3, TSH, TPO Vitamin D, 25-OH, Total: D2, D3	Estradiol (E2) <input type="checkbox"/> DHEAS (DS) <input type="checkbox"/> Estradiol (E3) * <input type="checkbox"/> Progesterone (Pg) <input type="checkbox"/> Cortisol (C) <input type="checkbox"/> Testosterone (T) <input type="checkbox"/> Estrone (E1) * <input type="checkbox"/>	Thyroglobulin <input type="checkbox"/> FSH <input type="checkbox"/> Total T4 <input type="checkbox"/> IGF-1 <input type="checkbox"/> Testosterone, Total <input type="checkbox"/> Free T4 <input type="checkbox"/> Insulin, Fasting <input type="checkbox"/> DHEAS (DS) <input type="checkbox"/> Free T3 <input type="checkbox"/> hsCRP <input type="checkbox"/> Cortisol, Total <input type="checkbox"/> TSH <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> SHBG <input type="checkbox"/> TPO <input type="checkbox"/> Triglycerides (TG) <input type="checkbox"/> PSA <input type="checkbox"/> LH <input type="checkbox"/>
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7 Payment Select only one form of payment.

Check # _____ Credit Card (Please complete the enclosed authorization form)
 Amount \$ / / Send Itemized receipt Bill Insurance - Selected Carriers Only (Please complete the enclosed authorization form)

8 & 9 Client Signature (Must be 18 years or older or Guardian of Minor)

My signature indicates my request, authorization and/or consent for laboratory testing. I understand that tests are already administered. In compliance with state specific CLIA regulations Alison McAllister, ND who is an on staff physician at ZRT Laboratory consents the approval of all test orders. The final review of my test results by ZRT Physicians or their processes does not represent diagnosis or treatment. I am responsible for contacting my personal health care provider for follow-up and any interpretation of my test results.

9 Health Provider Information

Getwell
1234 Any Street
Anytown, OR 00000

For Laboratory Use Only

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