

SERVICE REQUISITION FORM

Patient Information

Full Name:

Date of Birth:

Gender: Male Female

Mailing Address:

City:

State/Province:

Zip/Postal Code:

Country:

*Email:

*Phone:

*The patient's email and phone number is needed to collect payment from the patient. Samples will not be processed until payment is received.

Select Panels to Order:

Abdominal Pain Panel
Autoinflammatory Dysfunction
Migraine Panel
Neuropathic Pain
Thyroid Dysfunction
Wellness SNP Panel

Healthcare Professional Information

Healthcare Professional Name:

National Provider Identifier (NPI):

Admin Contact:

Address:

City:

State/Province:

Zip/Postal Code:

Country:

Phone:

Fax:

Email:

Additional Ordering Instructions:

Healthcare Professional Signature Authorizing Services (Required)

I certify that I have discussed with this patient the medical reasons for ordering this service. I understand that Avantra Genetics may contact the patient to obtain required billing and processing information and that Avantra Genetics reserves the right to decline to process an order for genetic sequencing if the ordering requirements are not met. I understand that Next Generation Sequencing will be performed by Courtagen Life Sciences, Inc., after which I will receive a data-only report, without interpretation.

Please
Sign & Date

Does Patient Need Collection Kit?

Yes. Send kit to patient.

No. Patient already has kit.

FRM-00069.0002