**Labrix Clinical Services, Inc.**
16255 SE 130th Ave
Clackamas, OR 97015

*Neurotransmitters/Hormones*

# REQUISITION FORM

## 1 Patient Info

Please print - ALL fields required

First Name | Middle Initial | Last Name

Address

City | State | Zip

Phone | Email

Sex ☐ Male ☐ Female  Birth Date ___/___/___

***Samples Must Be Shipped The Next Business Day***
*See Instructions*

**DATE OF SALIVA SAMPLES:** **TIME OF SALIVA SAMPLES:**

___/___/___ MORNING _____ NOON _____ EVENING _____ NIGHT _____

**DATE OF URINE SAMPLE:** **TIME YOU WOKE UP:** **TIME OF URINE SAMPLE:**

___/___/___ MORNING _____ MORNING _____

**WOMEN ONLY**

Date of Last Menstrual Period ___/___/___ ☐ HYSTERECTOMY ☐ OVARIES REMOVED

## 2 Practitioner Info

**Provider (P):** Natural Therapeutics Holistic Spa
**Provider ID #:** 5539
**Address:** 6340 Camp Bowie Blvd
Fort Worth, TX 76116
USA
**Phone:** (817) 738-4904
**Fax:** (817) 900-8480

Ordering Clinician (Print)

Clinician Signature

NPI Number

ICD-9 (Diagnosis Code for Insurance Billing)

## 3 Patient Consent and Authorization

I authorize the Lab to test my samples. I have read and understand that the Lab recommends that I share any comments made regarding my test results, including recommendations, with my health care provider. The Lab has not asked me to discontinue treatment or care from any health care provider.

The Lab has given no guarantees, warranties or assurances, expressed or implied, concerning the services provided.

I understand that California State health law prohibits the testing of specimens collected or mailed from California without a written order from a physician authorized to prescribe in California (MD; DC; ND; PA; LAc; RD; DO, NP, pharmacist, nutritionist, health counselor, etc). If you are located in California, please include an order from your physician along with your specimen sample.

My signature indicates that I have read and understand the above statements.

**By checking this box I am confirming my samples were frozen prior to shipping:** ☐

Patient Signature _____ Date ___/___/___

## 4 Tests Requested (Practitioner Use Only)

*Practitioner Please Select:*

**Panel Orders:**

| | |
|---|---|
| __ **Neuro/Hormone Complete Plus Panel*** | [Serotonin, GABA, Dopamine, Epi, Norepi, Glutamate] CPT-84260, 82136, 82382, 82384, 82384, 82136<br>[E1,E2,E3,Pg,T,D,am/noon/eve/pm Cortisol] CPT-82679,82670,82677,84144,84402,82626,82530 x4 |
| __ **Neuro/Hormone Complete Panel** | [Serotonin, GABA, Dopamine, Epi, Norepi, Glutamate] CPT-84260, 82136, 82382, 82384, 82384, 82136<br>[E2, Pg, T, D, am/noon/evening/pm Cortisol] CPT-82670, 84144, 84402, 82626, 82530 x4 |
| __ **NeuroAdrenal Panel** | [Serotonin, GABA, Dopamine, Epi, Norepi, Glutamate] CPT-84260, 82136, 82382, 82384, 82384, 82136<br>[D, Cortisol x4] CPT- 82626, 82530 x4 |

***OR*** **Individual Orders:**

| | | | | | |
|---|---|---|---|---|---|
| **Hormones/CPT:** | __ E1 /82679 | __ E2 /82670 | __ E3 /82677 | __ Pg /84144 | __ T /84402 |
| | __ D /82626 | __ C. Morning /82530 | __ C. Noon /82530 | __ C. Evening /82530 | __ C. Night /82530 |
| **Neurotransmitters/CPT:** | __ Epinephrine /82384 | | __ Dopamine /82382 | | __ GABA /82136 |
| | __ Norepinephrine /82384 | | __ Serotonin /84260 | | __ Glutamate /82136 |

* The reference ranges and clinical relevance for EQ have not been established for males.

PATIENT ALSO COMPLETES SIDE TWO ▶ ▶ ▶

PATIENT'S NAME: _____

## 5 Symptoms

Please indicate the symptoms you are experiencing as; 0 (none), 1 (mild), 2 (moderate), 3 (severe).
For example if you are moderately anxious you would indicate this by darkening the 2 next to 'anxious' e.g. 0 1 **2** 3 Anxious

### ALL INDIVIDUALS

- 0 1 2 3 Increased Forgetfulness
- 0 1 2 3 Foggy Thinking
- 0 1 2 3 Difficulty Concentrating
- 0 1 2 3 Tearful
- 0 1 2 3 Depressed
- 0 1 2 3 Mood Swings
- 0 1 2 3 Stress
- 0 1 2 3 Anxious
- 0 1 2 3 Irritable
- 0 1 2 3 Nervous
- 0 1 2 3 Decreased Mental Sharpness
- 0 1 2 3 Morning Fatigue
- 0 1 2 3 Afternoon Fatigue
- 0 1 2 3 Evening Fatigue
- 0 1 2 3 Difficulty Getting Asleep
- 0 1 2 3 Difficulty Staying Asleep
- 0 1 2 3 Decreased Stamina
- 0 1 2 3 Increased Muscle Aches
- 0 1 2 3 Fibromyalgia
- 0 1 2 3 Ringing in Ears
- 0 1 2 3 Allergies
- 0 1 2 3 Headaches/Migraines
- 0 1 2 3 Dizzy Spells
- 0 1 2 3 Constipation
- 0 1 2 3 Goiter
- 0 1 2 3 Cold Body Temperature
- 0 1 2 3 Sugar Cravings
- 0 1 2 3 Addictive Behavior
- 0 1 2 3 Craving Food, Alcohol, Tobacco, or Other
- 0 1 2 3 Hoarseness
- 0 1 2 3 Hair Dry or Brittle
- 0 1 2 3 Nails Breaking or Brittle
- 0 1 2 3 Slow Pulse Rate
- 0 1 2 3 Rapid Heartbeat
- 0 1 2 3 Heart Palpitations
- 0 1 2 3 Incontinence
- 0 1 2 3 Hot Flashes
- 0 1 2 3 Night Sweats
- 0 1 2 3 Infertility Problems
- 0 1 2 3 Acne
- 0 1 2 3 Scalp Hair Loss
- 0 1 2 3 Weight Gain-Hips
- 0 1 2 3 Weight Gain-Waist
- 0 1 2 3 High Cholesterol
- 0 1 2 3 Elevated Triglycerides
- 0 1 2 3 Decreased Libido
- 0 1 2 3 Decreased Muscle Size
- 0 1 2 3 Decreased Flexibility
- 0 1 2 3 Burned Out Feeling
- 0 1 2 3 Sore Muscles
- 0 1 2 3 Increased Joint Pain
- 0 1 2 3 Neck or Back Pain
- 0 1 2 3 Bone Loss
- 0 1 2 3 Thinning Skin
- 0 1 2 3 Rapid Aging
- 0 1 2 3 Aches and Pains

Height (inches) _____

Weight (lbs) _____

### WOMEN ONLY

- 0 1 2 3 Vaginal Dryness
- 0 1 2 3 Irregular Periods
- 0 1 2 3 Uterine Fibroids
- 0 1 2 3 Water Retention
- 0 1 2 3 Tender Breasts
- 0 1 2 3 Fibrocystic Breasts
- 0 1 2 3 Increased Facial / Body Hair

Last Menses ___/___/_____

### MEN ONLY

- 0 1 2 3 Decreased Urine Flow
- 0 1 2 3 Increased Urinary Urge
- 0 1 2 3 Prostate Problems
- 0 1 2 3 Decreased Erections

## 6 Hormone Use

List all hormone(s) you have used in the past 2 months *(see example)*.
If none are used, check here: ☐

| HORMONE THERAPIES | Example | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| Name of Hormone | Testosterone | | | | |
| Brand or Source | Compounded | | | | |
| Delivery | Topical | | | | |
| Amount (mg) | 1 mg | | | | |
| Date & Time Last used prior to sample collection | 03 / 17 / 12<br>8 30 AM PM | _____ AM PM | _____ AM PM | _____ AM PM | _____ AM PM |
| How Often | Once a day/everyday | | | | |
| How Long Used | For 10 months | | | | |

Does anyone in your household use topical hormones? ☐ Yes ☐ No

## Medications, Amino Acids Use

Check all amino acids and/or medications you have used in the past 2 months. If none are used, check here: ☐

### MEDICATIONS/SSRIs

- ☐ Anti-Anxiety Medication
- ☐ Anti-Depressant
- ☐ Anti-Psychotic Medication

### AMINO ACIDS

- ☐ 5-HTP
- ☐ GABA
- ☐ Glutamine
- ☐ Melatonin
- ☐ SAMe
- ☐ Theanine
- ☐ Tryptophan
- ☐ Tyrosine

COMMENTS: (Please do not use additional sheets of paper)

Internal Use Only

*5539*