


PATIENT INFORMATION (BLOCK LETTERS ONLY)			
Given Name <b>Narelle</b>		Surname <b>Marjanovic</b>	
Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		Date of Birth <b>10/7/77</b>	
Address <b>16 Quest Terrace Coomera Q 4209</b>			
Phone <b>0431 588838</b>	Credit Card Details <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard	Expiry Date <b>/</b>	Amount Due \$
Billing Code (internal use)	Card Number	Cardholder Signature	

PRACTITIONER INFORMATION
Name <b>DEESA WEBB</b>
Address <b>19 LIP STREET MIAMI, QLD, 4220</b>
Phone <b>0412 215484</b>
Practitioner's Signature 

## Clinical Notes

Current Medications (please tick)		Last Dose taken:	
<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"/> Pregnenolone
<input type="checkbox"/> Testosterone	<input type="checkbox"/> DHT	<input type="checkbox"/> Arimidex	<input type="checkbox"/> Growth Hormone
<input type="checkbox"/> Indole-3-Carbinol			
Type of Medications (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	
Current Symptoms (please tick)			
<input type="checkbox"/> Hot Flashes	<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 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		

## Tests/Analyses Required

### PLEASE NOTE:

1. Results WILL NOT be released until payment is finalised.
2. Results will only be released to the referring practitioner. Results cannot be released directly to the patient.

**Candida Antibodies /  
Antigen 3001**

### Date Collected:

☐ 6hr ☐ 12hr ☐ 24hr Urine Volume: \_\_\_\_\_ mls

Sal 1T	Sal 2T	Sal 4T	Sal 5T	Sal 11T	B/Strip	B/Spot
U Spot	U 24hr	SST	EDTA	LiH	NaH	Other

- 1. Practitioner instructions for completing Request Form, specimen labelling and transport.**
  - a) If uncertain of collection requirements, please call our Customer Service staff on **1300 688 522** to confirm the correct procedures. This will avoid unnecessary and inconvenient recollections
  - b) Neatly print and complete all Patient details (Full name, current address, Date of Birth).
  - c) Referring practitioner should provide their full name and practice address and the details of any other "Copy to" practitioners.
  - d) Referring practitioners should provide adequate patient clinical history.
  - e) Referring practitioner should specify concisely the tests they require to be assessed, in the Tests Requested section.
  - f) Referring practitioner should sign the Request Form.
  - g) Accounts section, including the patient's credit card details section must be filled out.
  - h) Advise patients that ALL specimens are to be labelled with full name, date of birth, collection time and date of collection to avoid any delays in test results.
- 2. Pathology Collector/Nurse instructions.**
  - a) If uncertain of collection requirements, please call our Customer Service staff on **1300 688 522** to confirm the correct procedures. This will avoid unnecessary and inconvenient recollections
  - b) Please ensure that all Patient details (Full name, current address, Date of Birth) are complete.
  - c) Please ensure that all Referring Practitioner details are complete ( Full name, practice address and any other "Copy to" practitioners).
  - d) Please ensure that the Tests Requested section has been completed. If not, contact the practitioner to confirm the correct tests.
  - e) Please ensure the Accounts section, including the patient's credit card details section have been filled out.
  - f) ALL specimens are to be labelled with full name, date of birth, collection time and date of collection to avoid any delays in test results.
- 3. Patient Self-Collect kits instructions**
  - a) Please call Customer Service on **1300 688 522** to order your test collection kit.
  - b) When you receive your kit, open it up and follow the instruction sheet in the kit.
  - c) From the instruction sheet, check that all the kit components are in your kit. If not, call Customer Service on **1300 688 522** and we will send you out a new kit.
  - d) Follow the collection instructions in order to collect the sample correctly, and forward it to NutriPATH in the container provided.
- 4. Blood Specimen collection procedures**

NutriPATH has formal blood collection service arrangements with key medical pathology providers in each state. The details of these arrangements are outlined in the collection instructions of each blood samples collection kit. The collection centre should NOT charge the patient as NutriPATH will be billed through their corporate account. Once the blood sample/s are collected, the collection centre will either:

  - a) Forward the sample/s to NutriPATH (through their internal transport system) for testing, if the samples are perishable and required to be processed on dry ice.
  - b) Give the sample back to the patient to be forwarded to NutriPATH, via an overnight courier service for testing.
  - c) Give the sample back to the patient to be forwarded to NutriPATH, via Express Post service for testing.
- 5. Refund Policy**
  - a) Once test kits have been ordered and dispatched by NutriPATH, a \$50.00 cancellation fee will apply if no longer required by the patient.
  - b) If the sample has been collected and received by NutriPATH, no refund will apply.