



Phlebotomist/Provider Use Only (please select one): ☐ New Sample ☐ Replacement Sample
Date Specimen Collected: _____ Phlebotomist/Provider Initial Here: _____
VS Laboratory Use Only –
Date Specimen Received: _____ Specimen ID: _____

SAMPLE INFORMATION [PROVIDER TO COMPLETE]

PLEASE NOTE: PATIENTS MUST NOT TAKE FOLINIC ACID OR 5-MTHF FOR 48 HOURS PRIOR TO BLOOD DRAW.

Specimen Type: Serum (SST – serum separator collection tube)	Diagnosis:	Diagnosis Code(s):
Provider Preferred Method for Reporting: ☒ Email ☐ Fax ☐ Other:		

FACILITY INFORMATION [PROVIDER TO COMPLETE]

Provider Name:		Facility Name:	
NPI #:		Street Address:	
Telephone:	Secure Fax:	City:	State/Region:
Email:	Zip/Postal Code:	Country:	

Provider acknowledgement: I hereby confirm that the information, including the information related to medical necessity as provided on this form, has been provided to the patient specified below and/or their legal guardian about the test(s) to be performed, and the patient specified below and/or their legal guardian has given consent for the test(s) to be performed. I confirm that the person listed as the ordering provider who has signed below is authorized by law to order the test(s) requested herein.

Provider Signature:	Role/Title:	Date Signed:
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PATIENT INFORMATION

First Name:	Last Name:	Date of Birth (mm/dd/yyyy):	Gender: ☐ Male ☐ Female
Street Address:		Telephone:	
City:	State/Region:	Email:	
Zip/Postal Code:	Country:	Address & Contact details same for Responsible Party? ☐ Yes ☐ No	

PAYMENT INFORMATION

ReligenDx to bill AvoVita Wellness Directly

PATIENT CONSENT & AUTHORIZATIONS

Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my provider to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering provider. I understand that I am responsible for all charges for FRAT® testing.

PATIENT/PARENT/GUARDIAN SIGNATURE:	Date Signed:
Responsible Party Full Name (if other than patient):	Relationship to Patient:

Powered By:

