5110 Campus Drive, Suite 120/137 | Plymouth Meeting, PA 19462
Phone: 610-441-9050 | Fax: 610-537-5075 | Email: info@fratnow.com | Website: https://fratnow.com

FRAT®/VS Laboratory Use Only:

DOR	Origin	Rcv'd: Frozen / Not Frozen
Specimen ID	Tracking	

FRAT®
Folate Receptor Antibody Test

Phlebotomist Use Only

New Sample ☐ / Replacement Sample ☐			Storage Conditions (prior to shipping, if applicable): Refrigerated ☐ Frozen ☐
Date Specimen Collected: (mm/dd/yyyy)	Date Specimen Shipped: (mm/dd/yyyy)	Phlebotomist/Provider Initials:	Sample Type: Whole blood (in SST tube – do NOT freeze) ☐ Decanted serum (serum transferred to polypropylene tube) ☐

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

Ordering Provider Information [Provider to Complete]

Provider Name:		Facility Name:	
NPI #:		Facility Address (include Suite/Floor/Building #):	
Telephone:	Secure Fax:	City:	State/Region:
Email:		Zip/Postal Code:	Country:
Provider Preferred Method for Reporting: ☐Email ☐Fax ☐Other:		Diagnosis:	Diagnosis Code(s):

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:	**Provider Credentials:**	**Date Signed:**

Patient Information

Patient First Name:	Patient Last Name:	REF Lab ID (if applicable):	Patient Date of Birth (mm/dd/yyyy):	Patient Gender: ☐Male ☐Female
Parent/Legal Guardian Printed Full Name (if other than self):		Parent/Legal Guardian Relationship to Patient:		
Patient Home Address:		Shipping Address (if different than patient address):		
Apartment/Building/Floor #:		Apartment/Building/Floor #:		
City:	State/Region:	City:	State/Region:	
Zip/Postal Code:	Country:	Zip/Postal Code:	Country:	
Patient/Parent/Legal Guardian Phone Number:		Patient/Parent/Legal Guardian Email:		

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.

Patient/Parent/Legal Guardian Signature:	**Date Signed:**

Payment Information

Test fee has been paid AvoVita Wellness and ReligenDx will back charge AvoVita

FORM MUST BE COMPLETED PRIOR TO SENDING THE SPECIMEN – INCOMPLETE FORMS WILL DELAY REPORTING

RELIGEN

Religen Inc CLIA ID #: 39D2130307
Reference Lab: Vascular Strategies LLC CLIA ID #: 39D2109943
FRAT® PATENT NO: US7,846,672 B2
RI-FMS-0019 version 03; Effective date: 09.01.2026