Labrix Clinical Services, Inc.
619 Madison St. Suite 100
Oregon City, OR 97045

SALIVA REQUISITION FORM S

1 Individual Info

Please Print–ALL fields required

First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Birth Date _____ Sex ○ MALE ○ FEMALE

DATE OF SAMPLES **TIME OF SAMPLES**

___/___/___ MORNING _____ NOON_____ EVENING _____ NIGHT _____

WOMEN ONLY

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

2 Provider Info

Provider: Mountain Health Chiropractic & Wellness

Provider ID #: 1731

Address: 1108 W Parker Rd Ste 102
Plano, TX 75075

Phone: (972) 398-0440
Fax: (972) 398-6948

Ordering Clinician (Print)

Clinician Signature

ICD-9 (Diagnosis Code for Insurance Billing)

3 Consent and Authorization

I authorize the Lab to test my saliva. 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 New York State health law prohibits the testing of specimens collected in or mailed from New York. I acknowledge that the specimen I have provided was not collected in New York.

I understand that California State health law prohibits the testing of specimens collected or mailed from California without a written order from a health care provider authorized to prescribe in California. (M.D.; D.C.; N.D.; P.A.; L.Ac; R.D.; D.O., pharmacist, nutritionist, health counselor, N.P., etc). If you are located in California, please include the approval of your care provider along with your specimen sample.

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

Signature _____ **Date** ___/___/___

4 Tests Requested

__ **Comprehensive Hormone Panel (8 tests)**	[E2, Pg, T, D, am/noon/evening/pm Cortisol] CPT-82670, 84144, 84402, 82626, 82530 x4
__ **Short Comprehensive Panel (6 tests)**	[E2, Pg, T, D, am/pm Cortisol] CPT-82670, 84144, 84402, 82626, 82530 x2
__ **Basic Hormone Panel (5 tests)**	[E2, Pg, T, D, am Cortisol] CPT-82670, 84144, 84402, 82626, 82530
__ **Adrenal Function Panel (5 Tests)**	[am/noon/evening/pm Cortisol, and DHEA] CPT-82530 x4, 82626
__ **Cortisol Panel (4 Tests)**	[am/noon/evening/pm Cortisol] CPT-82530 x4
__ **Abbreviated Cortisol (2 Tests)**	[am/pm Cortisol] CPT-82530 x2
__ **Estradiol (E2)**	CPT-82670
__ **Progesterone (Pg)**	CPT-84144
__ **Testosterone (T)**	CPT-84402
__ **DHEA (D)**	CPT-82626
__ **Estriol (E3)**	CPT-82677

CONTINUE ON OTHER SIDE ▸ ▸ ▸

PATIENT'S NAME: _____

5 Symptoms

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

WOMEN ONLY

- ☐☐☐☐ Hot Flashes
- ☐☐☐☐ Night Sweats
- ☐☐☐☐ Vaginal Dryness
- ☐☐☐☐ Incontinence
- ☐☐☐☐ Bleeding Changes
- ☐☐☐☐ Uterine Fibroids
- ☐☐☐☐ Water Retention
- ☐☐☐☐ Tender Breasts
- ☐☐☐☐ Fibrocystic Breasts
- ☐☐☐☐ Increased Forgetfulness
- ☐☐☐☐ Foggy Thinking
- ☐☐☐☐ Tearful
- ☐☐☐☐ Depressed
- ☐☐☐☐ Mood Swings
- ☐☐☐☐ Stress
- ☐☐☐☐ Morning Fatigue
- ☐☐☐☐ Evening Fatigue
- ☐☐☐☐ Difficulty Sleeping
- ☐☐☐☐ Decreased Stamina
- ☐☐☐☐ Anxious
- ☐☐☐☐ Irritable
- ☐☐☐☐ Nervous
- ☐☐☐☐ Fibromyalgia
- ☐☐☐☐ Allergies
- ☐☐☐☐ Headaches
- ☐☐☐☐ Sugar Cravings
- ☐☐☐☐ Dizzy Spells
- ☐☐☐☐ Cold Body Temperature
- ☐☐☐☐ Goiter
- ☐☐☐☐ Hoarseness
- ☐☐☐☐ Hair Dry or Brittle
- ☐☐☐☐ Nails Breaking or Brittle
- ☐☐☐☐ Constipation
- ☐☐☐☐ Slow Pulse Rate
- ☐☐☐☐ Rapid Heartbeat
- ☐☐☐☐ Heart Palpitations
- ☐☐☐☐ Infertility Problems
- ☐☐☐☐ Acne
- ☐☐☐☐ Increased Facial / Body Hair
- ☐☐☐☐ Scalp Hair Loss
- ☐☐☐☐ Weight Gain-Hips
- ☐☐☐☐ Weight Gain-Waist
- ☐☐☐☐ High Cholesterol
- ☐☐☐☐ Elevated Triglycerides
- ☐☐☐☐ Decreased Libido
- ☐☐☐☐ Decreased Muscle Size
- ☐☐☐☐ Thinning Skin
- ☐☐☐☐ Ringing in Ears
- ☐☐☐☐ Rapid Aging
- ☐☐☐☐ Aches and Pains
- ☐☐☐☐ Bone Loss
- ☐☐☐☐ Height (inches)_____
- ☐☐☐☐ Weight (lbs)_____

MEN ONLY

- ☐☐☐☐ Decreased Urine Flow
- ☐☐☐☐ Increased Urinary Urge
- ☐☐☐☐ Prostate Problems
- ☐☐☐☐ Weight Gain-Chest / Hips
- ☐☐☐☐ Weight Gain-Waist
- ☐☐☐☐ Decreased Libido
- ☐☐☐☐ Decreased Erections
- ☐☐☐☐ Ringing in Ears
- ☐☐☐☐ High Cholesterol
- ☐☐☐☐ Elevated Triglycerides
- ☐☐☐☐ Hot Flashes
- ☐☐☐☐ Night Sweats
- ☐☐☐☐ Decreased Mental Sharpness
- ☐☐☐☐ Increased Forgetfulness
- ☐☐☐☐ Decreased Muscle Size
- ☐☐☐☐ Decreased Flexibility
- ☐☐☐☐ Sore Muscles
- ☐☐☐☐ Increased Joint Pain
- ☐☐☐☐ Neck or Back Pain
- ☐☐☐☐ Bone Loss
- ☐☐☐☐ Rapid Aging
- ☐☐☐☐ Thinning Skin
- ☐☐☐☐ Decreased Stamina
- ☐☐☐☐ Burned Out Feeling
- ☐☐☐☐ Stress
- ☐☐☐☐ Morning Fatigue
- ☐☐☐☐ Evening Fatigue
- ☐☐☐☐ Difficulty Sleeping
- ☐☐☐☐ Apathy
- ☐☐☐☐ Depressed
- ☐☐☐☐ Mental Fatigue
- ☐☐☐☐ Anxious
- ☐☐☐☐ Irritable
- ☐☐☐☐ Nervous
- ☐☐☐☐ Headaches
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- ☐☐☐☐ Heart Palpitations
- ☐☐☐☐ Infertility Problems
- ☐☐☐☐ Allergies
- ☐☐☐☐ Height (inches)_____
- ☐☐☐☐ Weight (lbs)_____

6 Hormone Product Use

Indicate any hormone(s) you have used in the past 2 months as shown in the example below.

HORMONE THERAPIES	examples	1	2	3	4
hormone type	Estrogen Progesterone Testosterone DHEA Cortisol				
brand used	Compounded				
delivery	Topical, Oral, Sublingual				
amount (mg/day)	20 mg/day				
date & time last used prior to sample collection	4/29/06 8:30pm				
# x's/day & days/month	Once/14 days				
how long used	6-months				

COMMENTS: (Please do not use addional sheets of paper.)

Internal Use Only