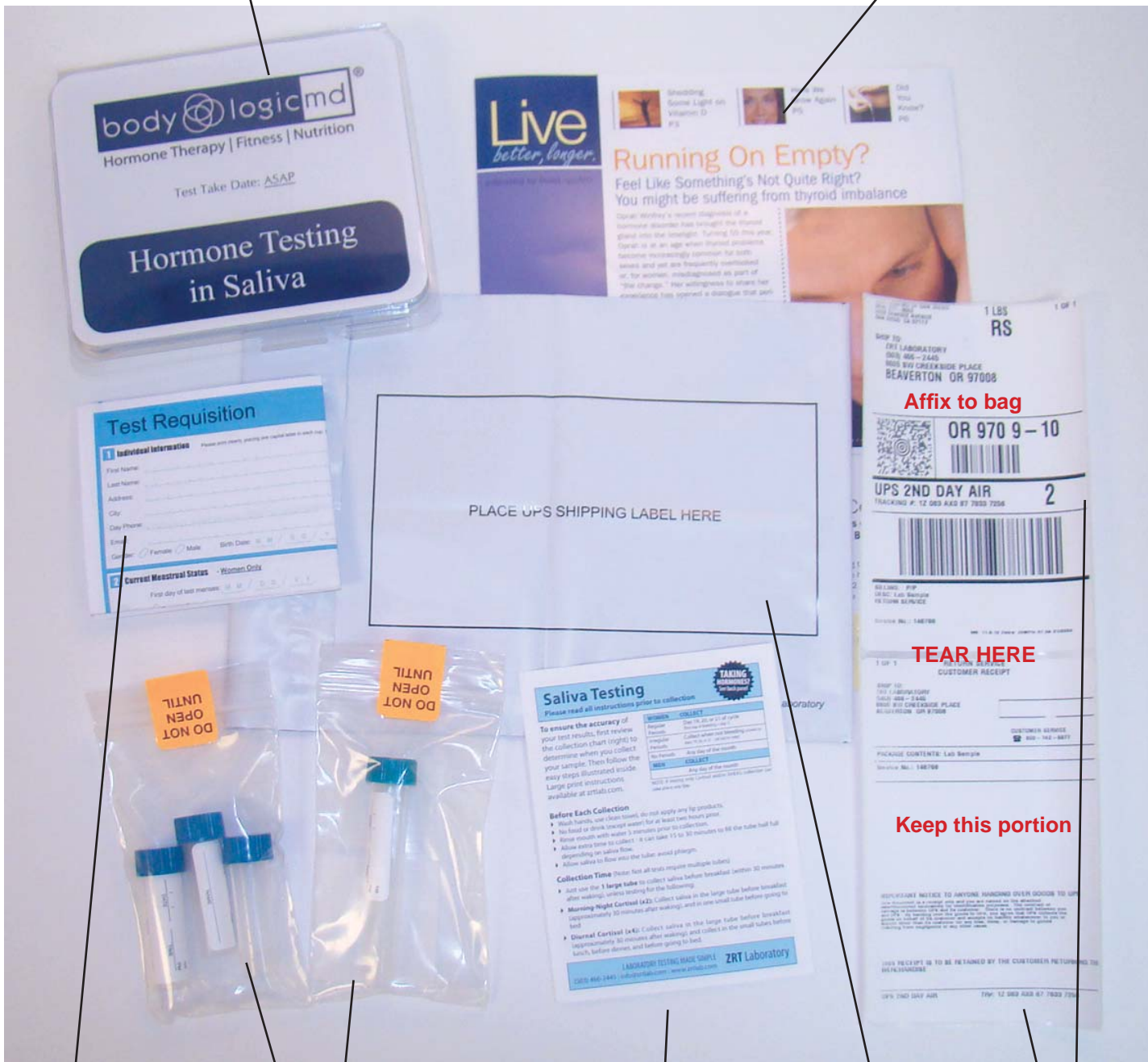


Saliva Kit

Newsletter



Test Requisition

Saliva Collection Tubes

Saliva Instructions

Return Shipping Bag

Return Shipping Label and Receipt

Test Requisition

Please encourage your patients to complete all sections on both sides of the form.

Side A

Section 1

Individual Information: name, address, phone, gender, date of birth etc.

Section 2

Current Menstrual Status (women): this is important for determination of the appropriate expected hormonal range.

Section 3

Symptoms: reported by patient. Symptom severity is key to evaluating patient hormonal health. A rating of 0 = none, 1 = mild, 2 = moderate, 3 = severe is reported in bar graph form on page two of the test report. This allows correlation of tested hormone levels with reported symptoms, thus providing a more comprehensive evaluation.

Section 3a

Basal Body Temperature: basal body temperature is optional and only requested when evaluating thyroid dysfunction.

Side B

Section 4

Hormone/Medication Use: prescribed dosage, delivery (e.g. topical, sublingual) and exact time of last dose are extremely important for accurate evaluation of test results.

Section 5

Sample Collection Date and Time: indicate the date(s) and time(s) that each sample was collected.

Section 6

Panels and Tests: indicates the hormone(s) and/or panel(s) to be tested

Section 7

Payment: indicates that BodyLogic MD is to be billed for lab tests.

Section 8

Client Signature: for authorization and/or consent for laboratory testing.

Section 9

Health Provider Information: appropriate BodyLogic information prints here.

Test Requisition BodyLogic MD

1 Individual Information Please print clearly, placing one capital letter in each oval. This will help us process your test better, quickly.

First Name: _____ MI: _____
 Last Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Day Phone: _____
 Email: _____
 Gender: Female Male Birth Date: MM/DD/YY Height: H I N Weight: L B S

2 Current Menstrual Status - Women Only

1st day of last menses: MM/DD/YY Hysterectomy: No Yes
 Regular Cycles Ovaries Removed: No One Both Year: YY
 Irregular Cycles Currently Pregnant: No Yes
 No Menstrual Cycles If currently pregnant, list the month of pregnancy: _____

3 Symptoms Please use the symptoms for your gender. Indicate the symptoms you are experiencing as: 0 (none), 1 (mild), 2 (moderate), or 3 (severe). For example, if you are moderately stressed you would indicate this by darkening the 2 next to 'Stress':

For Women

Hot Flashes	0 1 2 3	Night Sweats	0 1 2 3	Vaginal Dryness	0 1 2 3	Incontinence	0 1 2 3
Foggy Thinking	0 1 2 3	Memory Lapses	0 1 2 3	Tenderness	0 1 2 3	Depressed	0 1 2 3
Heart Palpitations	0 1 2 3	Bone Loss	0 1 2 3	Stress Disturbed	0 1 2 3	Headaches	0 1 2 3
Aches and Pains	0 1 2 3	Fibromyalgia	0 1 2 3	Morning Fatigue	0 1 2 3	Evening Fatigue	0 1 2 3
Abdominal	0 1 2 3	Sensitivity To Chemicals	0 1 2 3	Overweight	0 1 2 3	Cold Body Temperature	0 1 2 3
Sugar Craving	0 1 2 3	Elevated Triglycerides	0 1 2 3	Weight Gain - Waist	0 1 2 3	Decreased Libido	0 1 2 3
Loss Scalp Hair	0 1 2 3	Increase Facial or Body Hair	0 1 2 3	Acne	0 1 2 3	Mood Swings	0 1 2 3
Tender Breasts	0 1 2 3	Bleeding Changes	0 1 2 3	Nervous	0 1 2 3	Irritable	0 1 2 3
Anxious	0 1 2 3	Water Retention	0 1 2 3	Fibrocystic Breasts	0 1 2 3	Uterine Fibroids	0 1 2 3
Weight Gain - Hips	0 1 2 3	Decreased Stamina	0 1 2 3	Decreased Muscle Size	0 1 2 3	Rapid Aging	0 1 2 3
High Cholesterol	0 1 2 3	Swelling or Puffy Eyes, Face	0 1 2 3	Slow Pulse Rate	0 1 2 3	Decreased Sweating	0 1 2 3
Hot Dry or Brittle	0 1 2 3	Nails Breaking or Brittle	0 1 2 3	Thinning Skin	0 1 2 3	Infertility Problems	0 1 2 3
Constipation	0 1 2 3	Rapid Heartbeat	0 1 2 3	Hearing Loss	0 1 2 3	Other	0 1 2 3
Hoarseness	0 1 2 3	Increased Urinary Urges	0 1 2 3	Low Blood Sugar	0 1 2 3	High Blood Pressure	0 1 2 3
Low Blood Pressure	0 1 2 3	Numbness - Feet or Hands	0 1 2 3	Other	0 1 2 3		

For Men

Barred Out Feeling	0 1 2 3	Apathy	0 1 2 3	Difficulty Sleeping	0 1 2 3	Increased Forgetfulness	0 1 2 3
Decreased Mental Sharpness	0 1 2 3	Depressed	0 1 2 3	Mental Fog	0 1 2 3	Irritable	0 1 2 3
Nervous	0 1 2 3	Anxious	0 1 2 3	Morning Fatigue	0 1 2 3	Evening Fatigue	0 1 2 3
Decreased Stamina	0 1 2 3	Decreased Muscle Size	0 1 2 3	Stomach Issues	0 1 2 3	Increased Joint Pain	0 1 2 3
Decreased Flexibility	0 1 2 3	Neck or Back Pain	0 1 2 3	Weight Gain - Breast or Hips	0 1 2 3	Weight Gain - Waist	0 1 2 3
Elevated Triglycerides	0 1 2 3	Sugar Craving	0 1 2 3	Heart Palpitations	0 1 2 3	Diary Spells	0 1 2 3
Headaches	0 1 2 3	Ringing in Ears	0 1 2 3	Cold Body Temperature	0 1 2 3	Abdominal	0 1 2 3
Sensitivity To Chemicals	0 1 2 3	Decreased Erections	0 1 2 3	Decreased Libido	0 1 2 3	Prostate Problems	0 1 2 3
Decreased Urine Flow	0 1 2 3	Increased Urinary Urges	0 1 2 3	Hot Flashes	0 1 2 3	Night Sweats	0 1 2 3
Swelling or Puffy Eyes, Face	0 1 2 3	Slow Pulse Rate	0 1 2 3	Rapid Aging	0 1 2 3	High Cholesterol	0 1 2 3
Hot Dry or Brittle	0 1 2 3	Thinning Skin	0 1 2 3	Decreased Sweating	0 1 2 3	Hot Dry or Brittle	0 1 2 3
Constipation	0 1 2 3	Hearing Loss	0 1 2 3	Infertility Problems	0 1 2 3	Hoarseness	0 1 2 3
Rapid Heartbeat	0 1 2 3	High Blood Pressure	0 1 2 3	Aggressive Behavior	0 1 2 3	Numbness - Feet or Hands	0 1 2 3
Low Blood Sugar	0 1 2 3	Other	0 1 2 3				
Other	0 1 2 3						

3a Basal Body Temperature Enter results for each day.

Day 1: _____ Day 2: _____ Day 3: _____

DDDD Please continue on the other side. (We need just a little more information and your signature too.)

3/22/2008, 80 Noun 75168, Combo RB, (1 of 1), Odean Clinic ©2008 ZRT Laboratory, LLC and Insight Information Systems, Inc. All rights reserved worldwide.

4 Hormone/Medication Use Please list any hormone(s) you have used in the past two months. Attach separate sheet if needed.

Hormone Type	Brand	Delivery	Dosage	Last Used Date	Time	Times Per Day	How Long Used
Example: Progesterone	XPC Orin	Vaginal	20mg	7/2/08	10:30 pm		2 yrs

Also list other medications or herbal supplements (black cohosh, etc.) you are taking that may affect hormone levels: (see our web site for detailed information)

5 Sample Collection Date and Time Please list the date and time(s) you collected each sample.

Sample Collection Date: MM/DD/YY Morning Saliva Collection Time: HH:MM:SS Noon Saliva Collection Time: HH:MM:SS Evening Saliva Collection Time: HH:MM:SS Night Saliva Collection Time: HH:MM:SS Blood Spot Collection Time: HH:MM:SS

6 Panels and Tests Please fill the oval for the panel(s) or individual test(s). If you select individual tests in addition to panels, please do not duplicate tests that are in a panel you have already selected.

Combination (Saliva and Blood Spot) Panels

- Comprehensive Hormone Profile Saliva: E2, Pg. T, DHEAS, C4x Blood Spot: FT3, FT4, TSH, TPO
- Custom Hormone Profile (Please select individual saliva and blood spot tests.)

Saliva Panels

<input type="radio"/> AM/PM Cortisol	C1, C4	<input type="radio"/> Estradiol (E2)	<input type="radio"/> DHEAS (DS)
<input type="radio"/> Dilute Cortisol	C1-4	<input type="radio"/> Progesterone (Pg)	<input type="radio"/> Cortisol Morning (C)
<input type="radio"/> Adrenal Function Test	C1-4, DS	<input type="radio"/> Estrone (E1)	<input type="radio"/> Cortisol Noon (C2)
<input type="radio"/> Hormone Profile I	E2, Pg. T, DS, C1	<input type="radio"/> Estrone (E3)	<input type="radio"/> Cortisol Evening (C3)
<input type="radio"/> Hormone Profile II	E2, Pg. T, DS, C1, C4	<input type="radio"/> Testosterone (T)	<input type="radio"/> Cortisol Night (C4)
<input type="radio"/> Hormone Profile III	E2, Pg. T, DS, C1-4		

Blood Spot Panels

<input type="radio"/> Complete Thyroid Profile	TSH, FT3, FT4, TPO	<input type="radio"/> IGF-1	<input type="radio"/> FSH
<input type="radio"/> Male Hormone Profile I	PSA, SHBG, T	<input type="radio"/> Free T4	<input type="radio"/> PSA
<input type="radio"/> Male Hormone Profile II	PSA, SHBG, T, IGF1	<input type="radio"/> Free T3	<input type="radio"/> SHBG
		<input type="radio"/> TSH	<input type="radio"/> Testosterone, Total (T)
		<input type="radio"/> TPO	<input type="radio"/> Insulin, Fasting
		<input type="radio"/> LH	

7 Payment Select only one form of payment

Bill Provider.
 Bill Medicare, Part B.

8 & 9 Health Provider Information (Must be 18 years or older or Guardian of Minor)

BodyLogic MD

For Laboratory Use Only

Diag. Codes

My signature indicates my request, authorization and/or consent for laboratory testing. I understand that test results are strictly informational. ZRT Physician's review of my test results and results does not represent diagnosis or treatment. I am responsible for contacting my personal health care provider for follow-up and interpretation of my test results.