

AONM FRAT[®] ORDER FORM

Phlebotomist Use Only (please select one): <input type="checkbox"/> NEW sample <input type="checkbox"/> Replacement	VS Laboratory Use Only:--
Date Specimen Collected:	Date Specimen Received:
Phlebotomist Initials Here:	Specimen ID:

SAMPLE INFORMATION [PRACTITIONER/PROVIDER TO COMPLETE]

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

FRAT Specimen Type: Serum	Diagnosis:	Diagnosis Codes:
SPECIMEN PREPARATION:		
<input type="checkbox"/> Centrifuged serum transferred to polypropylene tube, frozen (-20°C) until shipped <input type="checkbox"/> Centrifuged specimen in Serum Separator Tube (SST), refrigerated (4°C), sent same day		

FACILITY INFORMATION [PRACTITIONER/PROVIDER TO COMPLETE]

Practitioner Name:	Clinic Name:	
Street Address:		
Telephone:	Town/City:	County:
Email:	Postcode:	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 authorised by law to order the test(s) requested herein.	
Practitioner Signature:	Role/Title:	Date Signed:

PATIENT INFORMATION

First Name:	Surname:	Date of Birth: (dd/mm/yyyy)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:		Telephone:	
Town/City:	County:	Email:	
Postcode:	Country:	Address & Contact details same for responsible party? <input type="checkbox"/> YES <input type="checkbox"/> NO	

BILLING/PAYMENT INFORMATION

Payment is made directly to Academy of Nutritional Medicine (AONM) either online, by card, OR bank transfer.

BANK TRANSFER: Academy Of Nutritional Medicine (AONM), Barclays Bank, 28 Chesterton Road, Cambridge CB4 3EZ, UK
Sort code: 20-17-22 | Account number: 63880265 | IBAN: GB11 BUKB 2017 2263 8802 65 | SWIFT/BIC: BUKGBG22

Once the payment is confirmed AONM you will receive an **AONM Authorisation Code** by email.
If paid online this code will be on the receipt/confirmation of order you will have received by email.

AONM Authorisation Code*

Please insert code here →

PATIENT CONSENT & AUTHORISATIONS

Data Protection. Consent to data transfer and discharge from the duty of (medical) confidentiality. I hereby give my consent for my personal data and treatment data to be collected, stored, processed and used. I also agree that any data, which are necessary for invoice processing (e.g. name, date of birth, address, date of treatment, service codes, invoice sums, test numbers, treatment documentation) will be disclosed to "Academy of Nutritional Medicine (AONM), St. John's Innovation Centre, Cowley Road, Cambridge CB4 0WS" and "Religen Inc, 5110 Campus Drive Suite #120, Plymouth Meeting PA 19462" for the purpose of the creation of invoices or for collection of receivables or – if necessary – for judicial enforcement. In this respect I release my treating practitioner, AONM and Religen Inc and their employees from their obligation of (medical) secrecy. I also agree that the laboratory results, which are obtained within the scope of this laboratory order may be disclosed to my treating practitioner. This declaration of consent can be revoked at any time with effect for the future.

Terms and Conditions for Ordering: Medical and Diagnostic information

AONM cannot provide a medical diagnosis. AONM makes no claims whatsoever to be able to diagnose or treat medical conditions but to provide tests which could help individuals and practitioners improve the well-being. As a condition of ordering these tests, patients and practitioners accept that AONM has no liability for any results provided.

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:** _____

