## Submission Form:    Laboratory Order

**Requesting Clinic/Doctor:**

New Customer or if contact information has changed, please fill out the fields on page 2.

Patient Name:

Street: _____  ZIP: _____  City: _____

State: _____  Country: _____

Phone: _____  Fax: _____

E-mail: _____

please fill out if report is to be mailed to the patient (please complete in block capitals)

Date of Birth: _____  Sex:    m    f    Job: _____

Please provide patient DATE OF BIRTH and SEX for determination of urine creatinine.

Please specify profile type, follow sampling instructions outlined on the back, and use metal-free containers only. We cannot take responsibility for results if contaminated containers were used, wrong sampling took place and/or if wrong or inadequate information was given.

## Laboratory Test

### Single Element Testing          38.89 €          (per test and per element)

| | | | | | |
|---|---|---|---|---|---|
| Aluminum | Cobalt | Iridium | Niobium | Sodium | Ytterbium |
| Antimony | Copper | Iron | Palladium | Strontium | Zinc |
| Arsenic-total | Dysprosium | Lanthanum | Platinum | Tantalum | Zirconium |
| Barium | Erbium | Lead | Potassium | Tellurium | |
| Beryllium | Europium | Lithium | Praseodymium | Thallium | |
| Bismuth | Gadolinium | Lutetium | Rhenium | Thorium | |
| Boron | Gallium | Magnesium | Rhodium | Thulium | |
| Cadmium | Germanium | Manganese | Rubidium | Tin | |
| Calcium | Gold | Mercury | Ruthenium | Titanium | |
| Cerium | Hafnium | Molybdenum | Samarium | Tungsten | |
| Cesium | Indium | Neodymium | Selenium | Uranium | |
| Chromium | Iodine | Nickel | Silver | Vanadium | |

_____    _____

_____    _____

_____    _____

**Payment via:**          **Invoice to:**          Doctor          Patient

Credit Card          VISA      Mastercard  Card Number: _____

valid thru (MM/YY): _____      3-digit code: _____    Signature: _____

Bank transfer done at: _____    for € _____

**Payment was made to address: service@microtrace.de**

**Pre-Payment or Credit Card is Needed, otherwise samples will be held until payment is received.**

## Symptom Codes (list the three main ones):

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 Addiction | 8 Heart Problems | 15 Diabetes | 22 Hypercholesterolemia | 29 Leukemia | 36 PMS |
| 2 Allergies | 9 Eye Problems | 16 Ear Problems | 23 Hypertension | 30 Multiple Sclerosis | 37 Prostate Problems |
| 3 Anemia | 10 Constipation | 17 Epilepsy | 24 Hyperthyroidism | 31 Muscular Dystrophy | 38 Scoliosis |
| 4 Alopecia | 11 Chronic Diarrhea | 18 Fatigue | 25 Hypoglycemia | 32 Obesity | 39 Digestive Disorder |
| 5 Asthma | 12 Cystic Fibrosis | 19 Genito/Urinary | 26 Hypothyroidism | 33 Osteoporosis | 40 Autism/Asperger |
| 6 Arthritis | 13 Depression | 20 Headaches/Migraine | 27 Immune Deficiency | 34 Parkinson | 41 _____ |
| 7 Cancer | 14 Skin problems | 21 Hyperactive/Kinetic | 28 Learning Disorder | 35 Phlebitis | 42 _____ |

**Test material:**

**3-5ml EDTA Whole Blood**   **Serum (3ml)**   **Plasma (3ml)**

**Head hair sample (untreated)**   **pubic hair sample**   **beard sample**

**3ml Saliva**   **5gr Stool**   **Nail sample**

**5-7ml Urine**   before chelation = Baseline specimen

**5-7ml Urine**   _____ **h   total collection time (time bet. chelator intake and sampling)**

**Type of Chelation:**   DMPS oral   ( _____ )

**( quantity )**   DMPS i.v.   Dimaval   Unithiol   _____   ( _____ )
( Manufacturer )

DMSA oral   DMSA i.v.   ( _____ )

EDTA oral   EDTA Supp   ( _____ )

NaMgEDTA i.v.   NaCaEDTA i.v.   ( _____ )

ZnDTPA i.v.   ( _____ )

**other chelating agent (please list type and quantity):** _____

Please inform us which chelating agent or combination therapy was administered and in which quantity. Each chelator varies in binding capacity, this information helps us to better validate your results.

**Amount of detoxification treatments carried out so far:** _____

**Patient is smoker:**   Yes   No

**Date of Sampling:** _____   **Shipping Date:** _____

**Orientation range:**   Do not show on report

**Remarks:**
_____
_____

**New Customer or if contact information has changed,**   or   **Clinic/Doctor Stamp**

Address: _____

Phone: _____

Fax: _____

E-mail: _____

**Send Report to:**   Doctor   Patient   both addresses (€ 9,95 surcharge)

**Send Report via:**   Post   E-Mail   Fax

Single Report   Comparison Report   Previous Report   _____

**Informed consent for data protection**

I consent to my sample being collected by the responsible medical practitioner or alternative therapist, and being transmitted to Micro Trace Minerals GmbH ("MTM") for the purpose of possessing and performing the assay I have requested. Furthermore, I agree that MTM will send my sample material, my name and my date of birth to specialist laboratories in Germany for carrying out the test I have requested and that MTM will be notified of the result. If I wish to send MTM's test result to the responsible physician or alternative practitioner, I agree that he/she will view the test result to provide a diagnosis. I may revoke my consent at any time to the responsible physician or alternative practitioner or to Micro Trace Minerals GmbH. Until my consent is effectively revoked, the processing of my personal data will remain legal.
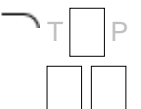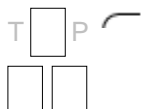
Details can be found in our privacy policy at: https://microtraceminerals.com/en/contact/data-protection/laboratory-order

By signing below, I certify that all information provided is correct.

Date: _____   **Patient Signature:** ___𝓍_____

**(please do not forget)**

Barcode UB   Barcode UA / UE / UPx / UZx   Barcode UR

This Form can also be filled out on the PC, please visit: https://microtraceminerals.com/en/submission-forms/