

# National Diagnostic Services

Please fill out completely and ship to  
National Diagnostic Services  
29620 Ashdale Way  
Quail Valley, CA 92587-9511

## NDS USE ONLY

Date Received: \_\_\_\_\_  
Time Received: \_\_\_\_\_  
Tubes Received: \_\_\_\_\_  
Sample Condition: \_\_\_\_\_  
Courier: \_\_\_\_\_

NDS  
USE  
ONLY

## Test Request

Physician's Name: \_\_\_\_\_ Patient's Name: \_\_\_\_\_  
Clinic Name: \_\_\_\_\_ Client's ID: \_\_\_\_\_  
Address: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date & Time Sample Collected: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date Sample Shipped: \_\_\_\_\_  
Send Results via  Fax Results  Mail Results  E-Mail Results: \_\_\_\_\_

Test(s) Requested:

Clinical/Differential Diagnosis:

History (clinical signs, nutrition, medication, environment, etc.):

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### Female Patients only

When did your last Menstrual Cycle begin? \_\_\_\_\_ or When did Menopause begin? \_\_\_\_\_

Treatments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If this is a resubmission, how have the patient's symptoms and conditions changed?

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I understand that all testing requested is for research purposes only and is not covered by insurance. I also release NDS and it's staff from all liability pertaining to the testing and results of this bloodwork. \_\_\_\_\_

Patient initials