



LAB ID. NUMBER

Please provide previous laboratory number if applicable.

SAMPLES SHOULD NOT BE OBTAINED FROM ANY PORTION OF HAIR THAT WAS PERMED, COLORED OR CHEMICALLY TREATED.

ACCOUNT NO.: Please email results
SUBMITTED BY: LAST NAME: Kazer FIRST NAME: Diane DEGREE: FDN
STREET: 344 San Tropez Court
CITY: Laguna Beach STATE: CA ZIP: 92651 TEL #: 3109556565

TYPE OF SAMPLE:
[] SCALP [] PUBIC [] AXILLARY
[] OTHER

NOTE: "Normal levels" and interpretations are based upon hair obtained from several areas of the occipital region of the scalp.

PATIENT: LAST NAME: FIRST NAME:
SEX: AGE:(REQUIRED): OCCUPATION:
ETHNIC ORIGIN: [] CAUCASIAN [] HISPANIC [] BLACK/AFRICAN-AMERICAN [] ASIAN [] OTHER
NATURAL HAIR COLOR: [] BLONDE [] BROWN [] BLACK [] GREY [] RED PREGNANT? [] YES [] NO
CURRENT MEDICATIONS: 1. 2. 3.

SHAMPOO AND OTHER HAIR PREPARATIONS:
DYES

REQUIRED — WAS THIS SAMPLE COLLECTED WITHIN THE STATE OF NEW YORK (PLEASE CHECK ONE) () YES () NO

PLEASE CHECK FIVE MOST PREDOMINANT SYMPTOMS: (CLINICAL DIAGNOSIS ONLY)

Grid of symptoms for selection: 101 ALLERGIES (RESP), 102 ALLERGIES (FOOD), 103 ALLERGIES (ECOL), 104 ANEMIA, 105 ASTHMA, 106 CANCER (TYPE), 107 CANDIDIASIS, 108 CATARACTS, 109 CYSTIC FIBROSIS, 110 DERMATITIS, 111 DIABETES, 112 ECZEMA, 113 EMPHYSEMA, 114 EPILEPSY, 115 FATIGUE, 116 GLAUCOMA, 117 HEADACHES, 118 HYPERKINESIS, 119 HYPERCALCEMIA, 120 HYPOGLYCEMIA, 121 INFECTIONS (BACTERIAL), 122 INSOMNIA, 123 IMMUNE DEFICIENCY (AIDS), 124 MONONUCLEOSIS, 125 PSORIASIS, 126 PERIODONTAL DISEASE, 127 SCLERODERMA, 128 VIRUSES, 130 CHRONIC FATIGUE SYNDROME, 132 HEMACHROMATOSIS, MUSCULO-SKELETAL, GASTRO-INTESTINAL, RENAL, 305 HYPERLIPIDEMIA, 306 HYPERTENSION, 307 HYPERTENSION (SYST), 308 HYPERTENSION (DIAS), 309 TACHYCARDIA, 310 BRADYCARDIA, 311 CORONARY OCCLUSION, 503 FREQUENT URINATION, 504 GOUT, 506 RENAL DISEASE, NEUROLOGICAL, EMOTIONAL, ENDOCRINE, MALE, FEMALE

PROFILE AND LANGUAGE REQUESTED
To Avoid Processing Delays Check Profile Desired

[] Profile 1: Test Results Only [] Profile 4: Test Results and Patient Report Only
[X] Profile 2: Test Results, Patient Report, Doctor Report, Dietary and Supplement Recommendations
[] Profile 3: (For Retest Only) Test Results, Patient Report, Dietary and Supplement Recommendations
LANGUAGE:

LABORATORY PAYMENT PLAN: [] Charge My Card [] MC [] VISA [] AMEX [] DISC # [] Prepare With Check No. [] Bill To My Account [] Send C.O.D. Expires:

SUPPLEMENT REQUEST: [X] No Supplements Requested [] One Month Supply [] Two Month Supply [] Three Month Supply

SUPPLEMENT PAYMENT PLAN: [] Charge My Card [] MC [] VISA [] AMEX [] DISC # [] Prepare With Check No. [] Bill To My Account [] Send C.O.D. Expires:

COMMENTS

FORM MUST BE COMPLETED IN ENTIRETY BY HEALTH CARE PROVIDER. FAILURE TO DO SO MAY RESULT IN PROCESSING DELAYS.

I understand that the interpretation or other information derived from the trace mineral analysis of the patient's hair, and the recommendations if implemented, will be based entirely upon my professional judgement and knowledge of the patient involved. I also hereby certify that the above information provided by this office is complete and accurate to the best of my knowledge.

PHYSICIAN/CLINICIAN: [Signature] DATE: