

# Understanding the Test Requisition

Below is an example of our Test Requisition form. It asks important questions about patient health and well-being. 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.

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Test Requisition

8605 SW Creekside Place  
 Beaverton, OR 97008  
 Phone: 503-466-2445 Fax: 503-466-1636  
 info@zrtlab.com www.zrtlab.com

**1 Individual Information** Please print clearly, placing one capital letter in each cup. This will help us process your evaluation quickly.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Gender:  Female  Male Birth Date:   /  /   Height:   /  /   Weight:   /  /   Waist Size:   /  /

**2 Current Menstrual Status - (Women Only)**

First day of last menses:   /  /   Hysterectomy:  No  Yes Year   /  /    
 Ovaries Removed:  No  One  Both Year   /  /    
 Currently Pregnant:  No  Yes # of Months   /    
 Regular Cycles  Irregular Cycles  No Menstrual Cycles

**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':

|  |   |  |  |
|--|---|--|--|
| <b>For Women</b>                             |   | <b>For Men</b>                                       |  |
| Hot Flashes <input type="checkbox"/>         | Night Sweats <input type="checkbox"/>                   | Burned Out Feeling <input type="checkbox"/>          | Apathy <input type="checkbox"/>                    |
| Foggy Thinking <input type="checkbox"/>      | Memory Loss <input type="checkbox"/>                    | Decreased Mental Sharpness <input type="checkbox"/>  | Depressed <input type="checkbox"/>                 |
| Heart Palpitations <input type="checkbox"/>  | Bone Loss <input type="checkbox"/>                      | Nervous <input type="checkbox"/>                     | Anxious <input type="checkbox"/>                   |
| Aches and Pains <input type="checkbox"/>     | Fibromyalgia <input type="checkbox"/>                   | Decreased Stamina <input type="checkbox"/>           | Decreased Muscle Size <input type="checkbox"/>     |
| Allergies <input type="checkbox"/>           | Sensitivity To Chemicals <input type="checkbox"/>       | Decreased Flexibility <input type="checkbox"/>       | Neck or Back Pain <input type="checkbox"/>         |
| Sugar Craving <input type="checkbox"/>       | Elevated Triglycerides <input type="checkbox"/>         | Elevated Triglycerides <input type="checkbox"/>      | Sugar Craving <input type="checkbox"/>             |
| Loss Scalp Hair <input type="checkbox"/>     | Increased Facial or Body Hair <input type="checkbox"/>  | Headaches <input type="checkbox"/>                   | Headaches <input type="checkbox"/>                 |
| Tender Breasts <input type="checkbox"/>      | Blowing Changes <input type="checkbox"/>                | Sensitivity To Chemicals <input type="checkbox"/>    | Decreased Erections <input type="checkbox"/>       |
| Anxious <input type="checkbox"/>             | Water Retention <input type="checkbox"/>                | Decreased Urine Flow <input type="checkbox"/>        | Increased Urinary Urges <input type="checkbox"/>   |
| Weight Gain - Hips <input type="checkbox"/>  | Decreased Estrogen <input type="checkbox"/>             | Swelling or Puffy Eyes/Face <input type="checkbox"/> | Sluggishness <input type="checkbox"/>              |
| High Cholesterol <input type="checkbox"/>    | Swelling or Puffy, Cystic Face <input type="checkbox"/> | Hair Dry or Brittle <input type="checkbox"/>         | Nails Breaking or Brittle <input type="checkbox"/> |
| Hair Dry or Brittle <input type="checkbox"/> | Nails Breaking or Brittle <input type="checkbox"/>      | Constipation <input type="checkbox"/>                | Rapid Heartbeat <input type="checkbox"/>           |
| Hoarseness <input type="checkbox"/>          | Rapid Heartbeat <input type="checkbox"/>                | Low Blood Pressure <input type="checkbox"/>          | Hoarseness <input type="checkbox"/>                |
| Low Blood Pressure <input type="checkbox"/>  | Increased Urinary Urges <input type="checkbox"/>        | Aggressive Behavior <input type="checkbox"/>         | Low Blood Pressure <input type="checkbox"/>        |
|  | Numbness - Feet or Hands <input type="checkbox"/>       |  | Aggressive Behavior <input type="checkbox"/>       |

**3a Basal Body Temperature and Hours Fasting**

|       |       |       |               |
|-------|-------|-------|---------------|
| Day 1 | Day 2 | Day 3 | Hours Fasting |
| ○     | ○     | ○     | ○             |

3a

## SIDE B

### Section 4

Hormone/Medication Use: prescribed dosage, 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: indicate the individual hormone(s) and/or panel(s) to be tested by checking the appropriate box(es).

### Section 7

Payment: indicates the Payment Option that you have chosen.

### Section 8

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

### Section 9

Health Provider Information: your name and address will print here.

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**4 Hormone/Medication Use** Please list any hormone(s) used in the past two months. Attach separate sheet, if needed, or attach photo copy of prescription(s) for hormone medications.

| Hormone Type          | Brand     | Delivery | Dosage | Date     | Time    | Times Per Day | How Long Used |
|-----------------------|-----------|----------|--------|----------|---------|---------------|---------------|
| Example: Progesterone | XXZ Cream | Topical  | 25 mg  | mm/dd/yy | 8:30 pm | 0             | days          |

Also list other medications or herbal supplements taken regularly.

**5 Sample Collection Date and Times**

| Saliva Collection Date |       | Blood Spot Collection Date |       |
|------------------------|-------|----------------------------|-------|
| h                      | m     | h                          | m     |
| Morning                | _____ | _____                      | _____ |
| Noon                   | _____ | _____                      | _____ |
| Evening                | _____ | _____                      | _____ |
| Night                  | _____ | _____                      | _____ |

**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. \* Estrone and Estradiol are currently not offered to New York residents

|   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Comprehensive Female Profile I<br>Saliva: E2, Pg, T, DS, Cx4<br>Blood Spot: FT4, FT3, TSH, TPO | <input type="checkbox"/> Comprehensive Female Profile II<br>Saliva: Cx4<br>Blood Spot: E2, E2, FT3, TSH, TPO | <input type="checkbox"/> Comprehensive Male Profile I<br>Blood Spot: PSA, FT4, FT3, TSH, TPO  | <input type="checkbox"/> Comprehensive Male Profile II<br>Blood Spot: E2, T, DS, SHBG, PSA, FT4, FT3, TSH, TPO |
| <input type="checkbox"/> Female/Male Saliva Profile I<br>E2, Pg, T, DS, C   | <input type="checkbox"/> Female/Male Saliva Profile II<br>E2, Pg, T, DS, Cx2                                 | <input type="checkbox"/> Female/Male Saliva Profile III<br>E2, Pg, T, DS, Cx4                 | <input type="checkbox"/> Adrenal Stress Profile<br>DS, Cx4   |
| <input type="checkbox"/> Diurnal Cortisol<br>Cx4  | <input type="checkbox"/> CardioMetabolic Profile<br>IN, hsCRP, HbA1c, TG, CH, HDL                            | <input type="checkbox"/> Essential Thyroid Profile<br>FT4, FT3, TSH, TPO                      | <input type="checkbox"/> Female Blood Profile I<br>E2, Pg, T, DS, C, SHBG                                      |
| <input type="checkbox"/> Female Blood Profile II<br>E2, Pg, T, DS, C, SHBG, FT4, FT3, TSH, TPO                          | <input type="checkbox"/> Male Blood Profile I<br>E2, T, DS, C, SHBG, PSA                                     | <input type="checkbox"/> Male Blood Profile II<br>E2, T, DS, C, SHBG, PSA, FT4, FT3, TSH, TPO | <input type="checkbox"/> Vitamin D, 25-OH, Total<br>D2, D3   |
| <input type="checkbox"/> Estradiol (E2)   | <input type="checkbox"/> DHEAS (DS)  | <input type="checkbox"/> Estradiol (E3) *   | <input type="checkbox"/> FSH   |
| <input type="checkbox"/> Progesterone (Pg)  | <input type="checkbox"/> Cortisol (C)  | <input type="checkbox"/> hsCRP  | <input type="checkbox"/> Total T4  |
| <input type="checkbox"/> Testosterone (T)   | <input type="checkbox"/> Estrone (E1) *  | <input type="checkbox"/> Free T4  | <input type="checkbox"/> Insulin, Fasting  |
| <input type="checkbox"/> Estradiol, Total   | <input type="checkbox"/> Thyroglobulin   | <input type="checkbox"/> Free T3  | <input type="checkbox"/> hsCRP   |
| <input type="checkbox"/> Progesterone, Total  | <input type="checkbox"/> Total T4  | <input type="checkbox"/> Free T3  | <input type="checkbox"/> Hemoglobin A1c  |
| <input type="checkbox"/> Testosterone, Total  | <input type="checkbox"/> Free T4   | <input type="checkbox"/> hsCRP  | <input type="checkbox"/> Triglycerides (TG)  |
| <input type="checkbox"/> DHEAS (DS)   | <input type="checkbox"/> Free T3   | <input type="checkbox"/> hsCRP  |  |
| <input type="checkbox"/> Cortisol, Total  | <input type="checkbox"/> TSH   | <input type="checkbox"/> hsCRP  |  |
| <input type="checkbox"/> SHBG   | <input type="checkbox"/> TPO   | <input type="checkbox"/> hsCRP  |  |
| <input type="checkbox"/> PSA  | <input type="checkbox"/> LH  | <input type="checkbox"/> hsCRP  |  |

**7 Payment** Select only one form of payment.

Check # \_\_\_\_\_  Credit Card (Please complete the enclosed authorization form)

Bill Insurance - Selected Carriers Only (Please complete the enclosed authorization form)

**8 & 9 Client Signature** (Must be 18 years or older or Guardian of Minor)

My signature indicates my request, authorization and/or consent for laboratory testing. I understand that tests are strictly informational. In compliance with state specific CLIA regulations Alison McAlister, ND who is an on staff physician at ZRT Laboratory consents the approval of all test orders. The final review of my test results by ZRT Physicians or their processes does not represent diagnosis or treatment. I am responsible for contacting my personal health care provider for follow-up and any interpretation of my test results.

**9 Health Provider Information**

Getwell  
 1234 Any Street  
 Anytown, OR 00000

For Laboratory Use Only

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