Dunwoody Labs

REQUISITION FORM

Dunwoody Labs
9 Dunwoody Park, Suite 121
Dunwoody, GA 30338
678-736-6374
770-674-1701 (fax)

SELECT YOUR PANEL

I hereby authorize the laboratory to perform the test(s) selected as indicated below. If no boxes are selected, I understand that the sample will be placed on hold.

I understand and hereby acknowledge that I am ordering tests that I believe to be medically necessary for my patient and request the confirmatory and/or quantative tests accordingly.

Provider Name Printed: 1. Required Field | Date: | Provider Signature: 2. Required Field

CLIENT TEST MENU

☐ Dietary antigen Test 588G & 588E or
Dietary Antigen Test IgG w/ Complement
Dietary Antigen Test IgE/IgG4 Mol...es

☐ 1000: Comprehensive Leaky Gut/Urinalysis/Toxicit...
☐ 1100: Female Hormone...
☐ 1110: Male Hormones
☐ 1200: Complete Thyroid
☐ 1600: Advanced Adrenal Stress Test
☐ 2000: Female Wellness Panel
☐ 2100: Male Wellness Panel
☐ 2950: Advanced Oxidative Stress
☐ 2960: Basic Oxidative Stress (Urine Only)
☐ 4001: Neurotransmitters

Individual Profiles

☐ DAT 588G (Only)
☐ DAT 588E (Only)
☐ ...0: Advanced Intestinal Barrier Asessment (DAO, Histamine, Zonulin & LPS)
☐ ...0: Comprehensive Stool w/Parasitology
☐ 6000: Oxidized LDL
☐ 6100: Complete Cardio w/ OxLDL
☐ 7000: Initial Screen
☐ Individual Analyte/Other: _____

3. Required Field

SPECIMEN INFORMATION

4. Required Field
Collection Date: / /

PRACTICE INFORMATION

Clinic: | NPI#:

Provider Name: 5. Required Field

Street Address: | City, State, Zip:

Phone: | Fax: | E-mail:

PATIENT INFORMATION

Last name: 6. Required Field | First name: 7. Required Field

Street Address: 8. Required Field | City, State, Zip: 9. Required Field

Phone: 10. Required Field | E-mail: | DOB: 11. Required Field | Sex: M ☐ F ☐

BILLING AND INSURANCE INFORMATION

☐ Client Pay
☐ Insurance Simple Pay Plan
☐ Patient Pay

Card# ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Exp. Date ☐☐/☐☐

Name on Card:

12. Required Field

Insurance: Please attach copy of front and back of primary and secondary insurance cards.

DIAGNOSIS CODES REQUIRED

Please check all the apply. Write additional codes in the space provided in this section.

These codes are provided as a convenience only; it is not a comprehensive list.

☐ Abnormal weight gain	R63.5	☐ Gastro-esophageal reflux disease w/esophagitis	K21.0	☐ Mixed hyperlipidemia	E78.2
☐ Adjustment disorder w/ depressed mood	F43.21	☐ Generalized anxiety disorder	F41.1	☐ Nonrheumatic mitral prolapse	I34.1
☐ Adjustment disorder w/mixed anxiesty & depression	F43.23	☐ Heartburn	R12	☐ Nontoxic multionodular goiter	E04.2
☐ Autoimmune thyroiditis	E06.3	☐ Hyperlipidermia	E78.5	☐ Other spec. disorders of adrenal gland	E27.8
☐ Candidiasis, unspecified	B37.9	☐ Hypogonadism	E29.1	☐ Other specified hypothyroidism	E03.8
☐ Chronic fatigue	R53.82	☐ Hypothyroidism	E03.9	☐ Other viral agents as the cause of disease	B97.89
☐ Dermatitis due to ingested food	L27.2	☐ Interstitial cystisis w/o hematuria	N30.10	☐ Primary pulmonary hypertension	I27.0
☐ Constipation	K59.00	☐ Irritable bowel syndrome w/ diarrhea	K58.0	☐ Pure hypercholesterolemia	E78.0
☐ Disorder of adrenal gland	E27.9	☐ Irritable bowel syndrome w/o diarrhead	K58.9	☐ Diabetes	E08.00
☐ Endocrine disorder	E34.9	☐ Lyme disease	A69.20		
☐ Functional diarrhea	K59.1	☐ Malabsorption due to intolerance	K90.4	☐ Additional Codes: _____	
☐ Gastritis	K29.7	☐ Menopausal & female climacteric states	N95.1		

13. Required Field

ASSIGNMENT OF BENEFITS AND CONSENT TO ACCESS TO LAB RESULTS

I authorize my insurance benefits to be paid directly to the lab for the services I have recieved. The lab is authorized to bill my insurance provider and to recieve payment of benefits for the tests my physicians orders. I further authorize the lab and my physician to release to my insurance provider any medical information necessary to this claim.

Patient Signature: 14. Required Field | Date: 15. Required Field