The Great Plains Laboratory, LLC

Test Requisition Form

Help us expedite your test(s) at www.gpltestinfo.com. Reference #: ________________
Information in red is required to process sample.

Patient Information (please print clearly)

First Name	Last Name	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	Age	Weight
Address	City	State (NY not accepted)	Zip Code	Country	
Phone	Email				

Our laboratory does NOT accept specimens from patients who reside in or practitioners who practice in the state of New York.

Practitioner Information (signature required to process sample)

First Name	Last Name	Credentials	
Institution	Phone	Fax	
Address	City	State (NY not accepted)	Zip Code / Country
Email		NPI	
Signature	☐ Practitioner Signature on File	Carevoyant ID (GPL Account Number)	

Method of Payment

☐ **Bill Practitioner** Practitioner's Name: ________________________________
Unavailable for practitioners that reside in the states of New Jersey, Rhode Island and New York.

☐ **Bill Insurance** GPL requires full patient cash price payment up-front PLUS a $40 filing fee per claim to be submitted along with the sample. After GPL has filed a claim on the patient's behalf, any insurance payment corresponding to the claim will be sent directly to the patient from the insurer. For questions, call 913-754-0459.

Patient Pay (select payment method below)

☐ Pay online at www.gp-labs.com/payments Transaction ID# ____________________

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover ☐ Money Order Amount $ ____________

Card # ________________________________ Exp. Date ________ Security Code ______

Name on Card ________________________________ Signature ____________________

ICD-10 Codes

Required for insurance:

1 - ____________________
2 - ____________________
3 - ____________________
4 - ____________________
5 - ____________________

Internal Use Only:

Person Responsible for Charges ☐ Same as patient

First Name	Last Name	Home Phone		
Email		Cell Phone		
Address	City	State/Province	Zip Code	Country

Primary Insurance (include photocopy of both sides of insurance card)

Company & Plan Name (ex. BCBS of Kansas City)	
Insurance Company Address	
Insurance Company Phone (required)	
Name of Insured	☐ Male ☐ Female
Date of Birth of Insured (MM/DD/YYYY)	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber Number	Group Number

Secondary Insurance (include photocopy of both sides of insurance card)

Company & Plan Name (ex. BCBS of Kansas City)	
Insurance Company Address	
Insurance Company Phone (required)	
Name of Insured	☐ Male ☐ Female
Date of Birth of Insured (MM/DD/YYYY)	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber Number	Group Number

Authorization of Testing, Acknowledgement of Insurance Procedures and Agreement to Cancellation Policy

I authorize and request payment of medical benefits be made directly to the guarantor listed for requested lab work. I authorize the release of any medical information necessary to file and process an insurance claim. I understand that certain tests are not billable to insurance (self-pay tests) thus GPL will not file a claim for these tests. Person responsible for charges authorizes GPL to process payment in full for tests requested (plus all applicable filing fees). I understand GPL does not guarantee insurance coverage by filing a claim. I permit a copy of this to be used in place of the original. Cancellation Policy: I have reviewed and agree to the cancellation policy located at www.greaplainslaboratory.com/cancellation-policy.

Patient/Guarantor *Signature* ________________________________ Date (MM/DD/YYYY) ______________

Specimen date and time of collection

Has urine been frozen? ☐ Yes ☐ No

Date of collection required for ALL specimen types.
Time of collection required for stool and hormone samples.

STOP

URINE Collection Date (MM/DD/YYYY): ____________________

BLOOD Collection Date (MM/DD/YYYY): ____________________

STOOL 1 Collection Date (MM/DD/YYYY): ____________________ Collection Time: ___________ ☐ AM ☐ PM

STOOL 2 Collection Date (MM/DD/YYYY): ____________________ Collection Time: ___________ ☐ AM ☐ PM

SALIVA Collection Date (MM/DD/YYYY): ____________________

HAIR Collection Date (MM/DD/YYYY): ____________________ **Dried Blood Spot (DBS)** Collection Date (MM/DD/YYYY): ____________________

HORMONES TEST ONLY

Collection Date (MM/DD/YYYY): ______________________ Collection Time: Morning _______ Noon _______ Evening _______ Night _______

Sample frozen? ☐ Yes ☐ No

Check any applicable: ☐ Hysterectomy ☐ Ovaries removed First Day of Last Menstrual Period (MM/DD/YYYY): ______________________

Urine

- ☐ Organic Acids Test (OAT)
- ☐ MycoTOX Profile* (Mold Exposure)
  - ☐ Check if patient is taking mycophenolate mofetil (CellCept/Myfortic)
- ☐ Glyphosate Test*
- ☐ GPL-TOX Profile* (Toxic Non-Metal Chemicals)
- ☐ Microbial Organic Acids Test* (MOAT) (included in OAT)
- ☐ Amino Acids Test* ☐ Random Collect ☐ 24 Hr Total vol _____ mL
- ☐ Calcium + Magnesium Test*
- ☐ Metals Urine Test Select type of collection:
  - ☐ **Random** ☐ **24 Hour** Total vol. _____ mL ☐ **Timed** # of hours _____
  - ☐ Pre-Provoking ☐ Post-Provoking: Agent __________ Dosage __________

Stool

- ☐ Comprehensive Stool Analysis x2
- ☐ Metals Fecal Test
  - ☐ Pre-Provoking ☐ Post-Provoking agent __________ Dosage _____
  - Does patient have dental amalgams? ☐ No ☐ Yes – How many? _____
- ☐ Microbiology Test

Blood (Serum, RBC, Whole Blood)

- ☐ IgG Food MAP with *Candida* + Yeast (Serum)
- ☐ Mold IgE Allergy Test (Serum)
- ☐ IgE Allergy Advanced Combined (Serum)
- ☐ IgE Food Allergy Basic Test (Serum)
- ☐ IgE Food Allergy Advanced Test (Serum)
- ☐ IgE Inhalant Allergy Basic Test (Serum)
- ☐ IgE Inhalant Allergy Advanced Test (Serum)
- ☐ Metals Test: ☐ Whole Blood ☐ Red Blood Cell
- ☐ Advanced Cholesterol Profile (Serum)
- ☐ Amino Acids Plasma Test* (requires overnight fast)
- ☐ Copper + Zinc Profile (Serum)
- ☐ Homocysteine Test* (Serum)
- ☐ Iron + Total Iron-Binding Capacity Test (TIBC)* (Serum)
- ☐ Streptococcus Antibodies Profile (Serum)
- ☐ Vitamin D Test (Serum)

Hair

- ☐ Metals Hair Test

Combo and Test Panels

Extra charges may apply for combos/panels that DO NOT arrive in same UPS bag.

- ☐ **Autism Spectrum Disorders Panel** (OAT, GPL-TOX Profile*, Glyphosate*, IgG Food MAP, Adv. Cholesterol, Comp Stool Analysis*, Metals Hair, Omega-3*)
- ☐ **ENVIROtox Panel** (OAT, GPL-TOX Profile*, Glyphosate*)
- ☐ **ENVIROtox Complete Panel** (ENVIROtox Panel + MycoTOX*)
  - ☐ Check if patient is taking mycophenolate mofetil (CellCept/Myfortic)
- ☐ **Fibromyalgia Panel** (OAT, GPL-TOX Profile*, Glyphosate*, IgG Food MAP, Metals Hair, Omega-3*)
- ☐ **GPL Complete** (OAT, GPL-TOX Profile *, Glyphosate*, IgG Food MAP, Adv. Cholesterol, Comp Stool, Copper + Zinc, Ferritin, Metals Hair, Vitamin D)
- ☐ **GPL3 – DBS** (OAT, Metals Hair, IgG Food MAP)
- ☐ **GPL3 – Serum** (OAT, Metals RBC, IgG Food MAP)
- ☐ **Mental Health Panel** (OAT, GPL-TOX*, Glyphosate*, IgG Food, Amino Acids Plasma, Metals Hair, Omega-3*)
- ☐ **Mold IgE Allergy Test + MycoTOX Combo**
- ☐ **Organic Acids Test + IgG Food MAP Combo**

Dried Blood Spot

- ☐ IgG Food MAP with *Candida* + Yeast
- ☐ Omega-3 Index Complete* (DBS One-Spot Card)
- ☐ Vitamin D Test

Saliva

- ☐ DNA Methylation Pathway Profile* **(requires Informed Consent form)**
- ☐ Hormones Comprehensive Plus Panel
  - Estrone, Estradiol, Estriol, Progesterone, Testosterone, DHEA, 4x Cortisol
- ☐ Hormones Comprehensive Panel
  - Estradiol, Progesterone, Testosterone, DHEA, 4x Cortisol

Other

- ☐ ____
- ☐ ____

May we use your test data for research purposes?

☐ Yes ☐ No NO IDENTIFYING INFORMATION WILL BE RELEASED

If yes, please check boxes applicable to this patient.

☐ ADD/ADHD ☐ Alzheimer's ☐ Asperger's
☐ Autism Spectrum Disorders ☐ Chronic fatigue ☐ Colitis
☐ Crohn's disease ☐ Depression ☐ Down syndrome
☐ Fibromyalgia ☐ Irritable bowel ☐ Multiple sclerosis ☐ OCD
☐ PDD ☐ Psychosis ☐ Schizophrenia ☐ Tourette's /Tics
☐ Other (please list): ______________________________

Signature: ______________________________________

* denotes that the test is not billable to insurance