Affix VS Specimen Identification Label Here

# FRAT™
Folate Receptor Antibody Test

FRAT AUTISM

5110 Campus Drive, Suite #150 | Plymouth Meeting, PA 19462
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## FACILITY INFORMATION (PLEASE PRINT IN BLUE or BLACK INK)

| | | | | | |
|---|---|---|---|---|---|
| Physician Name: | | | | Specimen Type | Date Specimen Collected: / Time Specimen Collected: |
| Facility Name: | | | | Telephone: | Secure Fax: |
| Street: | | | | Email: | |
| City: | State: | ZIP: | Country: | NPI #: | |
| Diagnosis: | | | | Diagnosis Code(s): | |
| Preferred method for receiving results: Email ☐ Fax ☐ Other ☐ | | | | Direct Bill Account Number: | |

**Physician acknowledgement**: I hereby confirm that the information, including the information related to medical necessity as provided on this form, has been provided to the patient specified below and/or their legal guardian about the test[s] to be performed, and the patient specified below and/or their legal guardian has given consent for the test[s] to be performed. I confirm that the person listed as the ordering physician who has signed below is authorized by law to order the test(s) requested herein.

**Physician Signature**:_____ Title:_____ Date:_____

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Patient First Name: | Patient Last Name: | | Responsible Party (if other than the patient): | | |
| DOB: | Male: ☐ Female: ☐ | | Relationship to Patient: | | |
| Street: | | | Street: | | |
| City: | State: | Zip: | City: | State: | Zip: |
| Telephone: | | | Telephone: | | |

**PLEASE NOTE: PATIENTS MUST NOT TAKE FOLINIC ACID OR 5-MTHF FOR 48 HOURS PRIOR TO BLOOD DRAW.**

## PAYMENT INFORMATION

**Cost of FRAT testing is $ 295**

**Bill to:** ☐ **Amex** ☐ **Visa** ☐ **Mastercard** ☐ **Discover** ☐ **Check enclosed made payable to Iliad Neurosciences, Inc.**

**Print Name on Card** _____

Credit Card Number:_____ Expiration Date: _____

Security Code (CVV):_____ Billing Zip Code: _____

Email to send receipt to: _____

**PLEASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING.**

## PATIENT CONSENT & AUTHORIZATIONS

**Patient acknowledgment:** My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Iliad Neurosciences, Inc. and for Iliad Neurosciences, Inc. to release the results of FRAT to the ordering physician. I understand that I am responsible for any and all charges for FRAT testing.

**PATIENT/PARENT/GUARDIAN SIGNATURE:** _____ Date: _____