Affix VS Specimen Identification Label

FRAT® Folate Receptor Antibody Test

5110 Campus Drive, Suite #150 | Plymouth Meeting, PA 19462
T: 610-441-9050 | F: 610-537-5075 | E: info@fratnow.com | https://fratnow.com

FACILITY INFORMATION (PLEASE PRINT IN BLUE or BLACK INK)

Physician Name:				Specimen Type:	Date Specimen / Time Specimen
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 Religen, 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 Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Powered By:

RELIGEN

Religen Inc CLIA #: 39D2130307
Reference Lab:
Vascular Strategies CLIA #: 39D2109943
FRAT® PATENT NO: US7,846,672 B2
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