5110 Campus Drive, Suite 120/137 | Plymouth Meeting, PA 19462
T: 610-441-9050 | F: 610-537-5075 | E: info@fratnow.com | https://fratnow.com

Phlebotomist/Provider Use Only (please select one): ☐ New Sample ☐ Replacement Sample

Date Specimen Collected: _____ Phlebotomist/Provider Initial Here: _____

VS Laboratory Use Only –

Date Specimen Received: _____ Specimen ID: _____

FRAT®

Folate Receptor Antibody Test

SAMPLE INFORMATION [PROVIDER TO COMPLETE]

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

Specimen Type: Serum (SST – serum separator collection tube)	Diagnosis:	Diagnosis Code(s):

Provider Preferred Method for Reporting: ☐Email ☐Fax ☐Other:

FACILITY INFORMATION [PROVIDER TO COMPLETE]

Provider Name:		Facility Name:	
NPI #:		Street Address:	
Telephone:	Secure Fax:	City:	State/Region:
Email:		Zip/Postal Code:	Country:

Provider 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 provider who has signed below is authorized by law to order the test(s) requested herein.

Provider Signature: **Role/Title:** **Date Signed:**

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth (mm/dd/yyyy):	Gender: ☐Male ☐Female
Street Address:		Telephone:	
City:	State/Region:	Email:	
Zip/Postal Code:	Country:	Address & Contact details same for Responsible Party? ☐ Yes ☐ No	

PAYMENT INFORMATION - (please select preferred payment method PRIOR to testing)

☐Credit Card	Name on Card:	Billing Zip/Postal Code:	
	Credit Card #:	Expiration Date:	Security Code (CVV):
☐Electronic Invoice	Email or Telephone (SMS Text) for invoice:		
☐Check Enclosed (payable to Religen, Inc.)	Check Amount: $	Check #:	

Email for Billing Communications:

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 provider 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 provider. I understand that I am responsible for all charges for FRAT® testing.

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

Responsible Party Full Name (if other than patient): **Relationship to Patient:**

Powered By:

RELIGEN

Religen Inc CLIA ID #: 39D2130307
Reference Lab: Vascular Strategies LLC CLIA ID #: 39D2109943
FRAT® PATENT NO: US7,846,672 B2
RI-FMS-0019 version 02; Effective date: 1/1/2025