Affix VS Specimen Identification Label Here

ENEVIA HEALTH

FRAT™

Folate Receptor Antibody Test

IλIAD Neurosciences

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

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: _____

Internal Use Only
Date Rec'd _____
Date Sent _____
Initials _____

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Patient Request to Access or to Disclose Protected Health Information (PHI)

In order for us to identify the requested patient PHI, please complete all information. Using the information provided, we will attempt to identify the laboratory test results and or order form.

Request Date: _____

PATIENT INFORMATION (PLEASE PRINT IN BLUE or BLACK INK)

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:		

TEST ORDER INFORMATION (PLEASE PRINT IN BLUE or BLACK INK)

Ordering Physician Name:				Approximate Date(s) of Service:
Facility Name:				Telephone:
Street:				
City:	State:	ZIP:	Country:	NPI #:

REQUESTED PHI: ☐ **Laboratory Test Results** ☐ **Order Form** ☐ **Other: _____**

REQUESTOR AUTHORIZATION

I request that Iliad Neurosciences search its records and provide me or the party named below in delivery instructions with a copy of the PHI requested.

Check one of the following as applicable:

☐ I am the patient named above.
or
☐ I am:
- ☐ Parent of patient
- ☐ Guardian of patient (Provide proof such as court order or power or attorney)
- ☐ Representative of patient (Provide proof such as court order, healthcare proxy, power of attorney)

Name (print): _____ Signature: _____

DELIVERY INSTRUCTIONS (check all that apply; please print):

☐ Patient/ Guardian/Representative Fax number _____ Email address _____
☐ Person(s) below

Name _____ Fax number _____ Email address _____

Name _____ Fax number _____ Email address _____

Please submit completed form (and any proof of representation, if required) to:

Fax: **1-610-537-5075**
Email: **lcontino@iliadneuro.com**