

National Diagnostic Services

Please fill out completely and ship to
National Diagnostic Services
4221 Pecan Bend Drive
Richmond, TX 77406-8601

NDS USE ONLY

Date Received: _____
Time Received: _____
Tubes Received: _____
Sample Condition: _____
Courier: _____

NDS
USE
ONLY

Test Request

Physician's Name: _____ Patient's Name: _____
Clinic Name: _____ Client's ID: _____
Address: _____ Date Of Birth: _____ Gender: _____
City: _____ State: _____ Zip: _____ Date & Time Sample Collected: _____
Phone: _____ Fax: _____ Date Sample Shipped: _____
Send Results via Fax Results Mail Results E-Mail Results: _____

Test(s) Requested:

Clinical/Differential Diagnosis:

History (clinical signs, nutrition, medication, environment, etc.):

Female Patients only

When did your last Menstrual Cycle begin? _____ or When did Menopause begin? _____

Treatments: _____

If this is a resubmission, how have the patient's symptoms and conditions changed?

I understand that all testing requested is for research purposes only and is not covered by insurance. I also release NDS and it's staff from all liability pertaining to the testing and results of this bloodwork. _____

Patient initials