MRT®
Test Requisition Form

LAB USE ONLY:
PLACE SPECIMEN ACCESSION LABEL HERE

Oxford Biomedical Technologies, Inc. ✦ 3555 Fiscal Court, Suite 9 ✦ Riviera Beach, FL 33404
Toll Free 888-669-5327 ✦ Ph. 561-848-7111 ✦ Fax 561-848-6655 ✦ FL State License #: 800027063 ✦ CLIA ID#: 10D0914874

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Ordering Practitioner:

Dr. Jack Pasula
3555 Fiscal Court, Ste. #9
Riviera Beach, FL 33404
Phone: 561-848-7111 NPI: 1235176314
Signature:

Lab Client:

Danielle VenHuizen, RD

652 SW 150th St.
Burien, WA 98166
Phone: (206) 274-9432 Fax: 206-274-4810
Email: danielle@foodsense.net

Patient Information: (Please Print Clearly)

Last Name	First Name	M.I.

Street Address	DOB (MM/DD/YYYY)

City	State	Zip	Gender
			☐ Male ☐ Female

Daytime Phone	Patient Email Address

Patient Medications

Please list name, dosage & frequency of all medications you are taking. Use back of form if you need more space

Medication Name	Dosage	Frequency

Health Reasons for Doing Test

☐ ADD/ADHD	☐ Eczema	☐ Migraine
☐ Arthritis (Any)	☐ Fibromyalgia	☐ PCOS
☐ Athletic Performance	☐ GERD	☐ Sinusitis
☐ Autism	☐ Headache	☐ Ulcerative Colitis
☐ Chronic Fatigue	☐ Insomnia	☐ Urticaria (Hives)
☐ Crohn's Disease	☐ Irritable Bowel	☐ Weight Mgmt.
☐ Diabetes	☐ Malaise	☐ Wellness

Select MRT Profile

- ☐ MRT 170 (4 Blue Tops)
- ☐ MRT 130 (4 Blue Tops)
- ☐ MRT 85 (4 Blue Tops)

Important
Draw Blood Mon – Fri After 12 Noon Local Time

Blood Draw

Time Collected:
☐ AM ☐ PM

Date Collected: (MM/DD/YY)

Payment Information

Note: *Oxford Biomedical Technologies does NOT TAKE any form of insurance as payment for MRT, nor will Oxford file claims or assist in processing claims for MRT. However, Oxford will provide a receipt to patients who pay Oxford directly for testing services (check box in Notes section below).*

Attn: Test results will not be released without full payment

Who is paying for the test?

- ☐ Lab Client
  - ☐ Credit Card on File
  - ☐ Credit Card
  - ☐ Check Enclosed
- ☒ Patient
  - ☐ Credit Card
  - ☐ Check (Payable to Oxford Biomedical Technologies)

DO NOT SEND CASH

Credit Card Information

Card Number:

Exp. Date	CVV	Amount

Name on Card

Signature

Credit Card Authorization
As cardholder, I understand that fees for testing services performed by Oxford Biomedical Technologies, Inc. (OBT) are my responsibility. My signature is evidence of my understanding. I authorize OBT to charge my credit card for all fees associated with testing.

This Section To Be Completed By Lab Client Only

LEAP Dietary Care

- ☒ I/my practice will provide Dietary Care
- ☐ I will refer patient to a local Certified LEAP Therapist
- ☐ Enroll patient in Oxford's Dietary Care Program (extra charges apply – Please enclose Starter Booklet)
- ☐ I decline Dietary Care – Testing for informational purposes only

Where to Send Results

Send Hardcopy to (Select One Only):
- ☐ Lab Client
- ☐ Patient

EMAIL Results:
- ☒ Email Results to Lab Client
- ☐ Email to different address:

Notes: ☐ **Please send patient a receipt to address above**