Affix VS Specimen Identification Label Here

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]

Physician Name:			Date Specimen Collected:	
Facility Name:			Telephone:	Secure Fax:
Street:			Email:	
City:	State:	Zip:	NPI #	
Diagnosis:			Diagnosis Code(s):	

Please indicate preferred method for receiving results: Email ☐ Fax ☐ Other ☐

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: Last Name:			Responsible Party: (if other than the patient)		
Date of Birth:	Male: ☐ Female: ☐		Relationship to Patient:		
Street:			Street:		
City:	State:	Zip:	State:	Zip:	City:
Telephone:			Telephone:		

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

PATIENT CONSENT AND AUTHORIZATIONS

Patient acknowledgement: My health care 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.

Patient Signature: _____ DATE: ____/____/____

Patient acknowledgement: State and federal privacy laws protect the use and release of your health information. Under these laws, your personal information cannot be released to the testing laboratory unless you give your permission. Such information includes, but may not be limited to, your name, date of birth, and diagnosis. The laboratory team will use and protect your information as closely as possible. However, once your health information is released it may not be protected by the privacy laws and might be shared with others. The information may be used by the testing laboratory, your physician, biopharmaceutical companies conducting research, and possibly regulatory agencies such as the FDA who review the quality and safety of the research and the data. If you agree to the use and release of your personal health information, please sign below. Upon request, you will be given a signed copy of this form.

Patient Signature: _____ DATE: ____/____/____

Patient acknowledgement: After testing is completed your remaining sample may be used for research purposes, such as the development of testing procedures and/or standards.

Patient Signature: _____ DATE: ____/____/____

PAYMENT INFORMATION

The cost of FRAT™ - $200
Charge: AMEX☐ VISA☐ MASTERCARD☐ DICOVER☐ CHECK ENCLOSED (PAYABLE TO ILIAD NEUROSCIENCES, INC) ☐
Card number:_____ **Expiration date:**_____
Security code (CVV2 – 3 digit number on back of Visa/MC, 4 digits on front of AMEX)_____ **Billing Zip Code:**_____
Cardholder signature:_____ **Date:**_____

VASCULARSTRATEGIES LLC

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