



Patient Details:

Title _____ DOB _____ Gender _____
Surname _____
Given Name _____
Address _____
Email _____
Phone _____

Requesting Doctor Details:

Pharmacy / Clinic Name _____
Name _____
Provider Number _____
Address _____
Phone _____
Email _____

(Where reports will be sent)

Copy Report To: (Practitioner name, provider number, fax number, email address)

Test Requested:

- Multiple Category Medication Test
 Mental Health Medication Test

Specimen Type: myDNA Buccal Kit

List Current Medications:

Is the patient a smoker?: Yes No

How to order a test:

Step 1

Purchase a Medication kit.

Step 2

Register your kit and nominate your healthcare professional.

Step 3

Swab and send back to the lab with this Request Form using the enclosed envelope.

Step 4

An email will notify you when your results are ready.

Step 5

Book an appointment with your doctor to discuss your results.

Requesting Doctor Signature _____ Date _____

(Signature not required for online orders)

- I hereby certify that I (detail above) personally collected the accompanying sample and that I labelled the sample immediately following collection (tick).