



HTMA SUBMITTAL FORM

(PLEASE PRINT)

LAB ID. NUMBER

Please provide previous laboratory number if applicable.

SAMPLES SHOULD NOT BE OBTAINED FROM ANY PORTION OF HAIR THAT WAS PERMED, COLORED OR CHEMICALLY TREATED.

SUBMITTED BY

ACCOUNT NO.:

LAST NAME: FIRST NAME: DEGREE:

STREET:

CITY: STATE: ZIP: TEL #:

TYPE OF SAMPLE:

SCALP PUBIC AXILLARY

OTHER

NOTE: "Normal levels" and interpretations are based upon hair obtained from several areas of the occipital region of the scalp.

PATIENT

LAST NAME: FIRST NAME:

SEX: AGE:(REQUIRED): OCCUPATION:

ETHNIC ORIGIN: CAUCASIAN HISPANIC BLACK/AFRICAN-AMERICAN ASIAN OTHER

NATURAL HAIR COLOR: BLONDE BROWN BLACK GREY RED PREGNANT? YES NO

CURRENT MEDICATIONS: 1. 2. 3.

SHAMPOO AND OTHER HAIR PREPARATIONS:

Blank lines for shampoo and other hair preparations.

DYES

REQUIRED - WAS THIS SAMPLE COLLECTED WITHIN THE STATE OF NEW YORK (PLEASE CHECK ONE) () YES () NO

PLEASE CHECK FIVE MOST PREDOMINANT SYMPTOMS: (CLINICAL DIAGNOSIS ONLY)

- 101 ALLERGIES (RESP)
102 ALLERGIES (FOOD)
103 ALLERGIES (ECOL)
104 ANEMIA
105 ASTHMA
106 CANCER (TYPE)
107 CANDIDIASIS
108 CATARACTS
109 CYSTIC FIBROSIS
110 DERMATITIS
111 DIABETES
112 ECZEMA
113 EMPHYSEMA
114 EPILEPSY
115 FATIGUE
116 GLAUCOMA
117 HEADACHES
118 HYPERKINESIS
119 HYPERCALCEMIA
120 HYPOGLYCEMIA
121 INFECTIONS (BACTERIAL)
122 INSOMNIA
123 IMMUNE DEFICIENCY (AIDS)
124 MONONUCLEOSIS
125 PSORIASIS
126 PERIODONTAL DISEASE
127 SCLERODERMA

- 128 VIRUSES
130 CHRONIC FATIGUE SYNDROME
132 HEMACHROMATOSIS

MUSCULO-SKELETAL

- 201 ARTHRITIS- OSTEO
202 ARTHRITIS-RHEUMATOID
203 BURSTITIS
204 CRAMPS (NIGHT)
205 CRAMPS (EXTETION)
206 DISC DEGENERATION
207 MUSCULAR DYSTROPHY
208 JOINT STIFFNESS
209 JOINT DISEASE
210 OSTEOPOROSIS
211 OSTEOMALACIA
212 OSTEOSARCOMA
213 PAGET'S DISEASE
214 SCOLIOSIS
216 FIBROMYALGIA
218 LUPUS

CARDIOVASCULAR

- 301 ANGINA
302 ARTIOSCLEROSIS
303 ATHEROSCLEROSIS
304 HYPERCHOLESTEROLEMIA

- 305 HYPERLIPIDEMIA
306 HYPERTENSION
307 HYPERTENSION (SYST)
308 HYPERTENSION (DIAS)
309 TACHYCARDIA
310 BRADYCARDIA
311 CORONARY OCCLUSION

GASTRO-INTESTINAL

- 400 CROHN'S DISEASE
401 COLITIS
402 CONSTIPATION
403 DIARRHEA
404 DIVERTICULOSIS
405 GASTRITIS
406 GALL STONES
407 HEPATITIS
408 LIVER DYSFUNCTION
409 LIVER CANCER
410 ULCERS - GASTRIC
411 ULCERS - DUODENAL
413 IRRITABLE BOWEL SYNDROME

RENAL

- 500 BLADDER DISTURBANCES
501 CALCIUM OXALATE STONES
502 CALCIUM PHOSPHATE STONES

- 503 FREQUENT URINATION
504 GOUT
506 RENAL DISEASE

NEUROLOGICAL

- 600 ALZHEIMER'S
601 A.L.S.
602 DYSLLEXIA
603 MULTIPLE SCLEROSIS
604 MYESTHENIA GRAVIS
605 PARKINSONS DISEASE
607 DEMENTIA
609 STROKE
611 TOURETTE'S SYNDROME

EMOTIONAL

- 701 ANXIETY
702 ATTENTION DEFICIT
703 AUTISM
704 DEPRESSION
705 HOSTILITY
706 LEARNING DISABILITY
707 MEMORY LOSS
708 SCHIZOPHRENIA
710 MANIC DEPRESSION

ENDOCRINE

- 801 HYPERADRENIA
802 HYPERPARATHYROID
803 HYPERTHYROID
804 HYPOADRENIA
805 HYPOPARATHYROID
806 HYPOTHYROID

MALE

- 901 IMPOTENCE
902 PROSTATE CANCER
903 PROSTATE ENLARGEMENT
904 PROSTATITIS

FEMALE

- 1001 AMMENORHEA
1002 BREAST TUMORS (BENIGN)
1003 BREAST TUMORS (MALIGNANT)
1004 MENSTRUAL BREAST SORENESS
1005 MENSTRUAL CRAMPS
1006 MENSTRUAL IRREGULARITY
1007 PROLONGED MENST. FLOW
1008 DECREASED MENST. FLOW
1009 PREMENSTRUAL SYNDROME
1011 FIBROCYSTIC DISEASE
1013 ENDOMETRIOSIS
1014 OVARIAN CYSTS

PROFILE AND LANGUAGE REQUESTED

To Avoid Processing Delays Check Profile Desired

Profile 1: Test Results Only

Profile 2: Test Results, Patient Report, Doctor Report, Dietary and Supplement Recommendations

Profile 3: (For Retest Only) Test Results, Patient Report, Dietary and Supplement Recommendations

Profile 4: Test Results and Patient Report Only

LANGUAGE:

LABORATORY PAYMENT PLAN

Prepay With Check No.:

Bill To My Account:

Send C.O.D.

Charge My Card

MC

VISA

AMEX

DISC

#

Expires:

SUPPLEMENT REQUEST

No Supplements Requested

One Month Supply

Two Month Supply

Three Month Supply

SUPPLEMENT PAYMENT PLAN

Prepay With Check No.:

Bill To My Account:

Send C.O.D.

Charge My Card

MC

VISA

AMEX

DISC

#

Expires:

COMMENTS

FORM MUST BE COMPLETED IN ENTIRETY BY HEALTH CARE PROVIDER. FAILURE TO DO SO MAY RESULT IN PROCESSING DELAYS.

I understand that the interpretation or other information derived from the trace mineral analysis of the patient's hair, and the recommendations if implemented, will be based entirely upon my professional judgement and knowledge of the patient involved.

I also hereby certify that the above information provided by this office is complete and accurate to the best of my knowledge.

PHYSICIAN/CLINICIAN

DATE