



TRACE ELEMENTS

E-Mail  Print - Results  Add Boron

HTMA SUBMITTAL FORM

(PLEASE PRINT)

Empty box for previous laboratory 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.

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.

SHAMPOO AND OTHER HAIR PREPARATIONS:

Empty lines for shampoo and hair preparations

DYES \_\_\_\_\_

ACCOUNT NO.: 9464  
SUBMITTED BY: LAST NAME: Mor FIRST NAME: Ronit DEGREE: ND  
STREET: 5148 Village Creek Dr Ste 300  
CITY: Plano STATE: TX ZIP: 75093 TEL #: 214-973-0482

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. \_\_\_\_\_

REQUIRED - WAS THIS SAMPLE COLLECTED WITHIN THE STATE OF NEW YORK (PLEASE CHECK ONE) ( ) YES (X) 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 4: Test Results and Patient Report 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
- 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.

R. Mor  
PHYSICIAN/CLINICIAN

DATE