AUTISM DIAGNOSTICS LAB
www.autismdiagnosticslab.com
info@autismdiagnosticslab.com
3805 E. Bell Rd., Ste 4300 Phoenix, AZ 85032

Requisition Form

1. PATIENT INFORMATION

- **Full Name: _____** **Date of Birth: ____ / ____ / _____**
- **Gender: [ ] M [ ] F** **Patient ID (to be filled by lab):**
- **Address: _____**
- **Phone: _____ Email: _____**
- **Parent/Guardian's Signature: _____Date: _____**

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2. ORDERING PROVIDER INFORMATION (REQUIRED FOR PHYSICIAN ORDERS AND FOR ORDERS FROM CA, CT, NJ, and RI STATES)

- **Doctor/ Physician's Name: _____ Facility/Clinic: _____**
- **Phone:**
- **Email:**
- **Preferred Test Report Delivery: [X] Email**
- **Ordering provider's Signature: _____Date: _____**

  (First time ordering providers have to send ADL a copy of their license).

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3. TEST SELECTION (Check all that apply)

MDM™ Gut and Brain Health Test Panel Plus

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4. BILLING INFORMATION

- **Bill To: [ ] Patient [ ] Doctor/Clinic**

  Credit/Debit card# **Exp. Date:** **Sec. Code:**

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5. SPECIMEN COLLECTION DATE/TIME

- **Collection Date: ____ / ____ / _____ Time: ____: ____ [ ] AM**