



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

TEST KIT ORDER FORM

Date of Order: _____

Name: _____

(Doctor)

(Clinic)

Address: _____

City, State, Zip: Phone: _____

E-mail: _____

Kit(s) requested:

Kit Name: MDM Gut & Brain Health Panel Qty. _____

PRACTICING LICENSE MUST BE ON FILE IN ORDER TO RECEIVE KITS

Please use this form and send it by email to info@autismdiagnosticslab.com whenever you wish to order kits. Test Kit requests will be processed generally within two days of receipt.

Send kit(s) to: Doctor / Patient

For residential deliveries (patient's location) fill the address form below:

Patient's First and Last Name/DOB: _____

Address: _____

City, State, Zip: _____