

**APA ASSAY REQUISITION FORM FOR PHYSICIANS AND RESEARCHERS**

*THIS COMPLETED FORM MUST ACCOMPANY SAMPLE*

**INSTRUCTIONS FOR OBTAINING SERUM SAMPLE:**

Collect a 7 ml blood specimen in a standard **UNCOATED RED-TOP** tube and allow the sample to clot without centrifugation. Separate the serum aseptically and transfer it to a vial for shipping. Refrigerate the serum until it is shipped. Ship the serum in a standard blood sample mailer.

**REQUISITIONS WITHIN THE U.S.:**

- (1) **The APA Assay, run in a qualitative strip format, is currently available as a service for research use.**
- (2) Ship the sample at room temperature *only Monday through Thursday* via **OVERNIGHT COURIER** to Autoimmune Technologies at the address below.
- (3) Include a check for the test fee of **\$145** with the sample unless prior arrangements have been made. Visa and MasterCard are also acceptable.

**REQUISITIONS OUTSIDE THE U.S.:**

- (1) **The APA Assay, run in a qualitative strip format, is currently available as a service for research use, and the APA ELISA Kit can be purchased outside the U.S.**
- (2) Ship the sample with frozen "blue" **GEL ICE PAKS** for **TWO-DAY DELIVERY** via DHL Worldwide Express or other courier to Autoimmune Technologies at the address below. To expedite the shipment at U.S. Customs, mark your invoice (on your stationery) or the courier's waybill as follows:
  - HUMAN BLOOD, NOT CONTAINED IN ANY MEDIUM
  - NOT INFECTIOUS AND NOT CONTAGIOUS
  - CONTAINS NO ANIMAL PRODUCTS
  - REASON FOR IMPORT: TO CONDUCT PATENTED LABORATORY TEST
- (3) Include either Visa or MasterCard authorization for the test fee of **\$145 US** with the sample unless prior arrangements have been made.

<b>Physician or Other Investigator Information</b>		
Name _____	Address _____	
City/State/Zip/Country _____	Telephone Number _____	Fax Number _____

<b>Patient Information</b>			
Name _____		Address _____	
City/State/Zip/Country _____	Telephone Number _____	Fax Number _____	
Date of Birth _____	Gender _____	Medical Record Number _____	Social Security (or Other) Number _____
Has patient used immunosuppressive agents or corticosteroids in the last six months? Yes ( ) No ( ) <b>SUCH USE MAY AFFECT THE TEST RESULTS</b>			
Differential diagnosis: _____		Current medications: _____	
Signs and symptoms: Tender Point count _____ ( ) Widespread pain ( ) Fatigue ( ) Morning stiffness ( ) Sleep disturbance ( ) Anxiety ( ) Paresthesias ( ) Headache ( ) Dysmenorrhea history ( ) Sicca symptoms ( ) Depression ( ) Irritable bowel syndrome ( ) Urinary urgency ( ) Raynaud's phenomenon ( ) Other _____			
Presence of implant of any type? Yes ( ) No ( ) Type of implant _____			
Date specimen collected: _____ Date shipped: _____ Lab contact name/phone: _____ / _____			

<b>Reporting</b>	<b>Payment</b>
Send Report to:	( ) Check enclosed ( ) VISA card ( ) MasterCard ( ) Other
( ) By mail	Name on card (or Billing Name, if Other) _____
( ) By fax, at _____	Card Number (or Billing Address, if Other) _____
	Expiration Date (or City, State, Zip, Country if Other) _____ Telephone _____

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The APA Assay is covered by U.S. Patent No. 5,620,859, European Patent No. 0873518, Australian Patent No. 710252, and other patents and pending patents.

Autoimmune Technologies Use Only: Date Received \_\_\_\_\_ Accession Number \_\_\_\_\_ Results \_\_\_\_\_