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Longevity™ LAB-SOLUTIONS Where Health Gets Perfected

Longevity Test Requisition Form

1. PATIENT INFORMATION (REQUIRED)

First Name_____ Last Name_____
DOB (mm/dd/yyyy) _____ Male Female Age_____
Address_____ ☐ ☐
City_____ State_____ Zip Code _____
Phone _____ Email_____

2. ORDERING PHYSICIAN INFORMATION (REQUIRED)

First Name_____ Last Name_____
Medical Credentials_____ NPI#_____
Facility Name_____
Address_____
City_____ State_____ Zip_____
Telephone:

3. SPECIMEN INFORMATION (REQUIRED)

Date of Collection_____ **Collected By**_____

Specimen Type ☐ SST ☐ Lavender ☐ Lt. Blue ☐ Gray ☐ Yellow ☐ Green ☐ Red ☐ Buccal ☐ Saliva ☐ Urine

4. GENERAL BLOOD TESTS REQUESTED

☐ ANEMIA PANEL	☐ BASIC METABOLIC PANEL (BMP)	☐ COMPREHENSIVE METABOLIC PANEL (CMP)	☐ LIPID PANEL
☐ COMPLETE BLOOD COUNT (CBC)	☐ DIABETES MANAGEMENT	☐ DIABETES RISK TEST	☐ FERRITIN
☐ FEMALE BASIC WELLNESS	☐ FEMALE ELITE WELLNESS	☐ FEMALE FERTILITY	☐ HEART HEALTH
☐ HORMONE PANEL	☐ IMMUNE HEALTH	☐ INFLAMMATION	☐ KIDNEY HEALTH
☐ LIVER HEALTH	☐ MALE BASIC WELLNESS	☐ MALE ELITE WELLNESS	☐ MICRONUTRIENTS (MINI)
☐ PROSTATE CANCER SCREENING	☐ TESTOSTERONE BLOOD TEST	☐ THYROID HEALTH	☐ VITAMIN B12
☐ VITAMIN D 25OH	☐ VITAMIN DEFICIENCY BLOOD TEST	☐ WEIGHT LOSS	

5. LONGEVITY TESTS REQUESTED

☐ LONGEVITY SIGNATURE BLOOD	☐ LONGEVITY SIGNATURE DNA	☐ LONGEVITY BRAIN	☐ LONGEVITY OXIDATIVE STRESS	☐ LONGEVITY MITOCHONDRIA
☐ LONGEVITY INFLAMMATION	☐ LONGEVITY HORMONE	☐ LONGEVITY MICRONUTRIENTS	☐ LONGEVITY SLEEP	☐ LONGEVITY CANCER

6. BIO-GPS TESTS REQUESTED

☐ BIO-GPS LONG COVID/NEUROINFLAMMATION	☐ BIO-GPS MOOD DISORDER	☐ BIO-GPS SLEEP	☐ BIO-GPS METHYLATION

7. INTELLIMIND TESTS REQUESTED

☐ IntelliMIND DNA MIND	☐ IntelliMIND BLOOD COMPREHENSIVE	☐ IntelliMIND METHYLATION MTHFR ☐ IntelliMIND METHYLATION DNA (3 genes) ☐ IntelliMIND METHYLATION BLOOD	☐ IntelliMIND ADHD	☐ IntelliMIND SLEEP

8. NUTRIGENOMICS TESTS REQUESTED

☐ NGX-HEALTH	☐ NGX-DIET	☐ NGX-SPORT	☐ NGX-HORMONE	☐ NGX-MIND	☐ NGS-SKIN

9. GENETICS TESTS REQUESTED

☐ APOE GENE FOR AD RISK	☐ MTHFR & COMT GENE MUTATIONS	☐ PHARMACOGENOMICS	
☐ CARDIOVASCULAR GENETICS	☐ CANCER GENETICS	☐ WHOLE EXOME SEQ	☐ OTHER TESTS

10. PATIENT INFORMED CONSENT

By signing below, I, the patient, confirm that I have been informed about the details of the test(s) ordered for me by my provider. I have read the informed consent and I give permission to Longevity Lab Solutions LLC to perform laboratory testing as described. I understand the risks, benefits and limitations of testing and I voluntarily consent to testing. I understand that I am responsible for all costs of testing ordered by my provider. I understand that testing not performed by this laboratory will be forwarded to another accredited reference laboratory. I understand and agree that my leftover specimen and clinical information may be used, without information directly identifying me, for research, education, and other business purposes of Longevity Lab Solutions LLC. I understand that this may involve Longevity Lab Solutions LLC sharing my leftover specimen and clinical information with other third parties. My leftover specimen and clinical information will be assigned a unique code before any secondary uses. My name or other personal identifying information will not be used in or linked to my specimen and clinical information when they are shared with third parties unless I explicitly authorize that disclosure. I understand that Longevity Lab Solutions LLC, itself or through its contractors on its behalf, may contact me regarding my interest in participating in other research activities, including contributing additional clinical information or specimens for use in such activities and/or authorizing the use of my identifiable information for secondary uses. I understand and agree that this authorization and consent is voluntary. More information is available at www.LongevityLabSolutions.com/policies/privacy-policy. This specimen was provided voluntarily for analysis and I authorize Longevity Lab Solutions LLC to process, bill and provide results. I authorize payment(s) to Longevity Lab Solutions LLC for any services provided to me by Longevity Lab Solutions LLC.

Patient Signature: _____ **Date:** _____

11. CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

I attest that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Longevity Lab Solutions LLC Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent. **STATEMENT OF MEDICAL NECESSITY:** By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

Ordering Provider Signature _____ **Date** _____