



**MUST BE COMPLETED BY AUTHORIZING/ORDERING PHYSICIAN**

Physician authorization for test order - fax to: 310.268.7461

ICD-10/DX Code: M.79.7-Fibromyalgia D83.1, D83.8, D89.89, R53.82

**PATIENT INFORMATION**

Prefix Last Name First Name

Street Address

City State Zip Code

Phone Fax Email

Test Requested (please circle) FM/a® - The FM Test

**PHYSICIAN INFORMATION**

Last Name First Name

Street Address

City State Zip Code

Phone Fax Email

Medications: Certain drugs, medications and supplements can interfere with the test process. These include steroids, anti-cancer drugs, anti-organ transplant drugs and any drugs that could affect the body's immune system, including some that are available over-the-counter. Does your patient take any of these drugs? Please check only one box. If YES, please list the medication below.

NO YES List Medications here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ordering Physician Date