



LICENSED HEALTHCARE PROVIDER AUTHORIZATION FORM

MUST BE COMPLETED BY THE AUTHORIZING/ORDERING PHYSICIAN

Physician authorization for test order—fax to: 310.552.1940

ICD-9/DX Code: M79.7-Fibromyalgia

PATIENT INFORMATION

Prefix	Last Name	First Name	
Street Address			
City	State	Zip Code	
Phone	Fax	Email	
Test Requested (please check):	FM/a®—The FM Test		

PHYSICIAN INFORMATION

DEGREE

Last Name	First Name	MD	DO	NP
Street Address		PA-C	ND	DC
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 medications below.

NO YES List medications here: _____

Ordering Physician's Signature _____ Date _____