EpicGenetics
We Sponsor Positivity℠

MUST BE COMPLETED BY REFERRING/ORDERING PHYSICIAN

Please fax form to: 310 861-9004

ICD-10/DX C: F D83.1, D83.8, D89.89

PATIENT INFORMATION

Last Name _____ First Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

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

PHYSICIAN INFORMATION NPI#_____

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: _____

_____

_____

_____

_____

SIGN HERE

_____

Referring Physician Signature Date