

**Test Requisition Form****Pharmacy.ca Tamoxifen CYP2D6 Pharmacogenetic DNA Test****Physician Section****Physician Information:** (You may staple your business card to this form)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email address: \_\_\_\_\_

**Patient Information:**Name: \_\_\_\_\_  
First Last

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ (Preferred contact number) Gender \_\_\_M \_\_\_F

Date of Birth (dd/mm/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Country of Birth: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Drug allergies: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Sample taken by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Patient Section****Patient Section** (Patient must complete and sign)**Payment Required:** Tamoxifen CYP2D6 Pharmacogenetic Test \$519.00\*

Cheque enclosed \_\_\_\_ (Make cheque out to Pharmacy.ca.) or Credit Card: \_\_\_ Visa \_\_\_ Master Card

Card number: \_\_\_\_\_ Expiry: Month \_\_\_\_\_ Year \_\_\_\_\_

Name on the Card: \_\_\_\_\_

Signature of Card Holder: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Patient Consent: By signing this form, I am consenting to allow Pharmacy.ca to share my health information as necessary with physicians whom prescribe for me and/or physicians whose care I am under, and other parties with whom it is necessary to do so in order to provide the service. I am providing my credit card information and consenting to allow Pharmacy.ca to bill my account for the Tamoxifen CYP2D6 Pharmacogenetic DNA Test in the amount specified above. I further consent to allow Pharmacy.ca to contact me by phone and/or email concerning my test and any related services that may be applicable.

\_\_\_\_\_  
*Patient signature*\_\_\_\_\_  
*Date*

\*This price includes the cost of the testing kit, the taking of the sample, sample shipping, sample conditioning, testing, and reporting of test results to the physician.

**Return completed form with sample to Pharmacy.ca in the prepaid Xpresspost envelope provided.**