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 $559.00*

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.

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