



HAIR TISSUE MINERAL ANALYSIS REQUEST

Please send hair sample accompanied with payment to:

InterClinical Laboratories Pty Limited
PO Box 6474 Alexandria NSW 2015 Australia
ACN 076 386 475

Phone: (02) 9693 2888
Fax: (02) 9693 1888
Email: lab@interclinical.com.au

Patient Details (Please write clearly)

SURNAME		FIRST NAME	
ADDRESS			
STATE		POSTCODE	
TELEPHONE		EMAIL	
AGE	SEX	PREGNANT <input type="checkbox"/> Yes <input type="checkbox"/> No	
HEIGHT	WEIGHT	OCCUPATION	
CURRENT MEDICATIONS			
REASON FOR TEST			

NB: Reference ranges on reports are based on age, gender and scalp hair. The information provided herein may be used for research purposes.

Sample Details

Samples should not be obtained from hair that is permed, coloured or chemically treated. Untreated hair provides the most reliable result.

DATE OF SAMPLE	DAY	MONTH	YEAR
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Any Previous Report? <input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES, PLEASE PROVIDE
LAB No.
DATE

LOCATION OF SAMPLE ie Scalp/Pubic/Axillary/Other

NATURAL HAIR COLOUR ie Black/Brown/Blonde/Red/Grey

HAIR PREPARATIONS ie Colour/Bleach/Perm/Other/None

SHAMPOO

***ALL REFERRED ANALYSIS REPORTS SHALL BE RETURNED IN FULL TO THE REFERRING PRACTITIONER**

Referred by

NAME	
TYPE OF PRACTITIONER	PROV/MEM No.
ADDRESS	
SUBURB	STATE POSTCODE
TELEPHONE	EMAIL
SIGNATURE	

TYPE OF REPORT (Please ✓) PROFILE 1 2 3 **Antimony** (extra fee applies)

OFFICE USE ONLY	LAB NUMBER	BATCH NUMBER
DATE RECEIVED	SAMPLE WEIGHT	AMOUNT RECEIVED

PRACTITIONER USE ONLY

PLEASE TICK 5 MOST PREDOMINANT SYMPTOMS (CLINICAL DIAGNOSIS ONLY)

- | | | |
|---|---|---|
| <input type="checkbox"/> 101 ALLERGIES (RESP) | <input type="checkbox"/> 214 SCOLIOSIS | <input type="checkbox"/> 604 MYESTHENIA GRAVIS |
| <input type="checkbox"/> 102 ALLERGIES (FOOD) | <input type="checkbox"/> 216 FIBROMYALGIA | <input type="checkbox"/> 605 PARKINSONS DISEASE |
| <input type="checkbox"/> 103 ALLERGIES (ECOL) | <input type="checkbox"/> 218 LUPUS | <input type="checkbox"/> 607 DEMENTIA |
| <input type="checkbox"/> 104 ANAEMIA | | <input type="checkbox"/> 609 STROKE |
| <input type="checkbox"/> 105 ASTHMA | | <input type="checkbox"/> 611 TOURETTE'S SYNDROME |
| <input type="checkbox"/> 106 CANCER.....(TYPE) | CARDIOVASCULAR | |
| <input type="checkbox"/> 107 CANDIDIASIS | <input type="checkbox"/> 301 ANGINA | EMOTIONAL |
| <input type="checkbox"/> 108 CATARACTS | <input type="checkbox"/> 302 ARTIOSCLEROSIS | <input type="checkbox"/> 701 ANXIETY |
| <input type="checkbox"/> 109 CYSTIC FIBROSIS | <input type="checkbox"/> 303 ATHEROSCLEROSIS | <input type="checkbox"/> 702 ATTENTION DEFICIT |
| <input type="checkbox"/> 110 DERMATITIS | <input type="checkbox"/> 304 HYPERCHOLESTEROLEMIA | <input type="checkbox"/> 703 AUTISM |
| <input type="checkbox"/> 111 DIABETES | <input type="checkbox"/> 305 HYPERLIDIPEMIA | <input type="checkbox"/> 704 DEPRESSION |
| <input type="checkbox"/> 112 ECZEMA | <input type="checkbox"/> 306 HYPERTENSION | <input type="checkbox"/> 705 HOSTILITY |
| <input type="checkbox"/> 113 EMPHYSEMA | <input type="checkbox"/> 307 HYPERTENSION (SYST) | <input type="checkbox"/> 706 LEARNING DISABILITY |
| <input type="checkbox"/> 114 EPILEPSY | <input type="checkbox"/> 308 HYPERTENSION (DIAS) | <input type="checkbox"/> 707 MEMORY LOSS |
| <input type="checkbox"/> 115 FATIGUE | <input type="checkbox"/> 309 TACHYCARDIA | <input type="checkbox"/> 708 SCHIZOPHRENIA |
| <input type="checkbox"/> 116 GLAUCOMA | <input type="checkbox"/> 310 BRADYCARDIA | <input type="checkbox"/> 710 MANIC DEPRESSION |
| <input type="checkbox"/> 117 HEADACHES | <input type="checkbox"/> 311 CORONARY OCCLUSION | |
| <input type="checkbox"/> 118 HYPERKINESIS | | ENDOCRINE |
| <input type="checkbox"/> 119 HYPERCALCEMIA | GASTRO-INTESTINAL | <input type="checkbox"/> 801 HYPERADRENIA |
| <input type="checkbox"/> 120 HYPOGLYCEMIA | <input type="checkbox"/> 400 CROHN'S DISEASE | <input type="checkbox"/> 802 HYPERPARATHYROID |
| <input type="checkbox"/> 121 INFECTIONS (BACTERIAL) | <input type="checkbox"/> 401 COLITIS | <input type="checkbox"/> 803 HYPERTHYROID |
| <input type="checkbox"/> 122 INSOMNIA | <input type="checkbox"/> 402 CONSTIPATION | <input type="checkbox"/> 804 HYPOADRENIA |
| <input type="checkbox"/> 123 IMMUNE DEFICIENCY (AIDS) | <input type="checkbox"/> 403 DIARRHOEA | <input type="checkbox"/> 805 HYPOPARATHYROID |
| <input type="checkbox"/> 124 MONONUCLEOSIS | <input type="checkbox"/> 404 DIVERTICULOSIS | <input type="checkbox"/> 806 HYPOTHYROID |
| <input type="checkbox"/> 125 PSORIASIS | <input type="checkbox"/> 405 GASTRITIS | |
| <input type="checkbox"/> 126 PERIODONTAL DISEASE | <input type="checkbox"/> 406 GALL STONES | MALE |
| <input type="checkbox"/> 127 SCLERODERMA | <input type="checkbox"/> 407 HEPATITIS | <input type="checkbox"/> 901 IMPOTENCE |
| <input type="checkbox"/> 128 VIRUSES | <input type="checkbox"/> 408 LIVER DYSFUNCTION | <input type="checkbox"/> 902 PROSTATE CANCER |
| <input type="checkbox"/> 130 CHRONIC FATIGUE SYNDROME | <input type="checkbox"/> 409 LIVER CANCER | <input type="checkbox"/> 903 PROSTATE ENLARGEMENT |
| <input type="checkbox"/> 132 HEMACHROMATOSIS | <input type="checkbox"/> 410 ULCERS - GASTRIC | <input type="checkbox"/> 904 PROSTRATITIS |
| | <input type="checkbox"/> 411 ULCERS - DUODENAL | |
| | <input type="checkbox"/> 413 IRRITABLE BOWEL SYNDROME | FEMALE |
| MUSCULO-SKELETAL | | <input type="checkbox"/> 1001 AMMENORRHEA |
| <input type="checkbox"/> 201 ARTHRITIS - OSTEO | RENAL | <input type="checkbox"/> 1002 BREAST TUMORS (BENIGN) |
| <input type="checkbox"/> 202 ARTHRITIS - RHEUMATOID | <input type="checkbox"/> 500 BLADDER DISTURBANCES | <input type="checkbox"/> 1003 BREAST TUMORS (MALIGNANT) |
| <input type="checkbox"/> 203 BURSITIS | <input type="checkbox"/> 501 CALCIUM OXALATE STONES | <input type="checkbox"/> 1004 MENSTRUAL BREAST SORENESS |
| <input type="checkbox"/> 204 CRAMPS (NIGHT) | <input type="checkbox"/> 502 CALCIUM PHOSPHATE STONES | <input type="checkbox"/> 1005 MENSTRUAL CRAMPS |
| <input type="checkbox"/> 205 CRAMPS (EXERTION) | <input type="checkbox"/> 503 FREQUENT URINATION | <input type="checkbox"/> 1006 MENSTRUAL IRREGULARITY |
| <input type="checkbox"/> 206 DISC DEGENERATION | <input type="checkbox"/> 504 GOUT | <input type="checkbox"/> 1007 PROLONGED MENST. FLOW |
| <input type="checkbox"/> 207 MUSCULAR DYSTROPHY | <input type="checkbox"/> 506 RENAL DISEASE | <input type="checkbox"/> 1008 DECREASED MENST. FLOW |
| <input type="checkbox"/> 208 JOINT STIFFNESS | | <input type="checkbox"/> 1009 PREMENSTRUAL SYNDROME |
| <input type="checkbox"/> 209 JOINT DISEASE | NEUROLOGICAL | <input type="checkbox"/> 1011 FIBROCYSTIC DISEASE |
| <input type="checkbox"/> 210 OSTEOPOROSIS | <input type="checkbox"/> 600 ALZHEIMERS DISEASE | <input type="checkbox"/> 1013 ENDOMETRIOSIS |
| <input type="checkbox"/> 211 OSTEOMALACIA | <input type="checkbox"/> 601 A.L.S | <input type="checkbox"/> 1014 OVARIAN CYSTS |
| <input type="checkbox"/> 212 OSTEOSARCOMA | <input type="checkbox"/> 602 DYSLEXIA | |
| <input type="checkbox"/> 213 PAGET'S DISEASE | <input type="checkbox"/> 603 MULTIPLE SCLEROSIS | |

ADDITIONAL NOTES

Payment Details

Please make cheque or money order payable to: InterClinical Laboratories Pty Limited
PO Box 6474 Alexandria NSW 2015 Australia

Alternatively please charge my Credit Card as payment for the Hair Tissue Analysis Report(s) requested



Credit Card Payment Authority

CREDIT CARD NUMBER

EXPIRY DATE / / MasterCard VisaCard

CARD HOLDERS NAME

SIGNATURE _____ DATE _____

Please Note: A 15% administration and processing fee is applicable upon cancellation prior to laboratory work.