MyTraitRx

PHARMACOGENOMIC TEST ORDER FORM

Requested Date

Patient's Name:

First Name

Last Name

Patient's Date of Birth

Patient's Phone Number

Patient's Email

Patient's Address:

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Provider's Name:

First Name

Last Name

Provider's Contact No

Providers contact info to send results

Pharmacogenomic testing order:

☐ Pharmacogenomic test only

☐ Pharmacogenomic test and med list review

Signature

Date

Once this form is submitted, the patient will be alerted via email to fill out the patient consent form on the website and pay for the test. Results will be sent to you and the patient. Any questions regarding results or potential prescriptions needed in the future can be sent to mytraitrx@gmail.com.