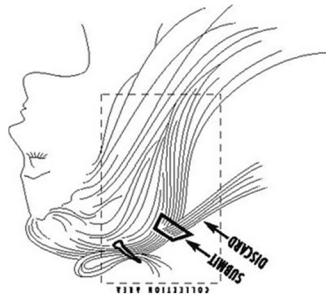


Fold 1
Fold 2
Fold 3

Fold 4

Location: Take small portions of each sample from at least 4 to 5 different areas of the scalp. Collect samples from the nape of the neck, posterior vertex, and posterior temporal regions. Scalp hair is the preferred choice for analysis. Other body hair, like pubic hair, should only be used if scalp hair is unavailable. Do not mix head hair from other areas of the body.



ACCOUNT NO.: 6663 (For internal use only)

SHAMPOO:

PATIENT NAME:

LAB NO. (RETEST ONLY):

Fold 5

Sample Preparation: Collect untreated hair that is not permed, dyed, or bleached. If all hair has been chemically treated, wait for new virgin growth before collecting. Untreated hair can usually be found beneath the nape. Ensure hair is free of gels, oils, and hair creams. Take precautions for those exposed to external contaminants between washing and collection.

Length: Use stainless steel scissors or thinning shears to cut the hair as close to the scalp as possible. Keep the length of the collected hair to 1.5 inches or less. Keep the proximal portion (the closest 1.5 inches to the root) and discard the excess.

Amount: The requested weight for a hair specimen is 125 milligrams (0.125 grams). If a hair weight scale is unavailable, one full teaspoon should be approximately the required weight.

Special Note: Every sample must have a completed HTMA Laboratory Submittal Form.

Email: service@hairmineralanalysis.health

TAPE HERE

TO SEAL

PLEASE MAKE SURE
SAMPLE GOES ALL THE WAY
DOWN TO THE BASE



Order No.: _____

TRACE ELEMENTS, INC.

TMA SUBMITTAL FORM

(PLEASE PRINT)

Leave highlighted
sections blank

LAB ID. NUMBER

Please provide previous
laboratory number if applicable.

ACCOUNT NO.: 6663

SUBMITTED BY

LAST NAME: _____ FIRST NAME: _____ DEGREE: _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____ TEL #: _____

PATIENT

LAST NAME: _____ FIRST NAME: _____

SEX: _____ AGE (REQUIRED): _____ OCCUPATION: _____

ETHNIC ORIGIN: ☐ CAUCASIAN ☐ HISPANIC ☐ BLACK/AFRICAN-AMERICAN ☐ ASIAN ☐ OTHER _____NATURAL HAIR COLOR: ☐ BLONDE ☐ BROWN ☐ BLACK ☐ GREY ☐ RED PREGNANT? ☐ YES ☐ NO

CURRENT MEDICATIONS: 1. _____ 2. _____ 3. _____

DYES _____

TYPE OF SAMPLE:

☐ SCALP ☐ PUBIC ☐ AXILLARY☐ OTHER _____NOTE: "Normal levels" and interpretations are based upon
hair obtained from several areas of the occipital region of
the scalp.

SHAMPOO AND OTHER HAIR PREPARATIONS:

REQUIRED — WAS THIS SAMPLE COLLECTED WITHIN THE STATE OF NEW YORK (PLEASE CHECK ONE) () YES () NO

PLEASE CHECK ☒ FIVE MOST PREDOMINANT SYMPTOMS: (CLINICAL DIAGNOSIS ONLY)

- ☐ 101 ALLERGIES (RESP)
- ☐ 102 ALLERGIES (FOOD)
- ☐ 103 ALLERGIES (ECOL)
- ☐ 104 ANEMIA
- ☐ 105 ASTHMA
- ☐ 106 CANCER _____ (TYPE)
- ☐ 107 CANDIDIASIS
- ☐ 108 CATARACTS
- ☐ 109 CYSTIC FIBROSIS
- ☐ 110 DERMATITIS
- ☐ 111 DIABETES
- ☐ 112 ECZEMA
- ☐ 113 EMPHYSEMA
- ☐ 114 EPILEPSY
- ☐ 115 FATIGUE
- ☐ 116 GLAUCOMA
- ☐ 117 HEADACHES
- ☐ 118 HYPERKINESIS
- ☐ 119 HYPERCALCEMIA
- ☐ 120 HYPOGLYCEMIA
- ☐ 121 INFECTIONS (BACTERIAL)
- ☐ 122 INSOMNIA
- ☐ 123 IMMUNE DEFICIENCY (AIDS)
- ☐ 124 MONONUCLEOSIS
- ☐ 125 PSORIASIS
- ☐ 126 PERIODONTAL DISEASE
- ☐ 127 SCLERODERMA

- ☐ 128 VIRUSES
- ☐ 130 CHRONIC FATIGUE SYNDROME
- ☐ 132 HEMACHROMATOSIS

- MUSCULO-SKELETAL
- ☐ 201 ARTHRITIS-OSTEO
 - ☐ 202 ARTHRITIS-RHEUMATOID
 - ☐ 203 BURSTITIS
 - ☐ 204 CRAMPS (NIGHT)
 - ☐ 205 CRAMPS (EXERTION)
 - ☐ 206 DISC DEGENERATION
 - ☐ 207 MUSCULAR DYSTROPHY
 - ☐ 208 JOINT STIFFNESS
 - ☐ 209 JOINT DISEASE
 - ☐ 210 OSTEOPOROSIS
 - ☐ 211 OSTEOMALACIA
 - ☐ 212 OSTEOSARCOMA
 - ☐ 213 PAGET'S DISEASE
 - ☐ 214 SCOLIOSIS
 - ☐ 216 FIBROMYALGIA
 - ☐ 218 LUPUS

- CARDIOVASCULAR
- ☐ 301 ANGINA
 - ☐ 302 ARTIOSCLEROSIS
 - ☐ 303 ATHEROSCLEROSIS
 - ☐ 304 HYPERCHOLESTEROLEMIA

- ☐ 305 HYPERLIPIDEMIA
- ☐ 306 HYPERTENSION
- ☐ 307 HYPERTENSION (SYST)
- ☐ 308 HYPERTENSION (DIAS)
- ☐ 309 TACHYCARDIA
- ☐ 310 BRADYCARDIA
- ☐ 311 CORONARY OCCLUSION

- GASTRO-INTESTINAL
- ☐ 400 CROHN'S DISEASE
 - ☐ 401 COLITIS
 - ☐ 402 CONSTIPATION
 - ☐ 403 DIARRHEA
 - ☐ 404 DIVERTICULOSIS
 - ☐ 405 GASTRITIS
 - ☐ 406 GALL STONES
 - ☐ 407 HEPATITIS
 - ☐ 408 LIVER DYSFUNCTION
 - ☐ 409 LIVER CANCER
 - ☐ 410 ULCERS - GASTRIC
 - ☐ 411 ULCERS - DUODENAL
 - ☐ 413 IRRITABLE BOWEL SYNDROME

- RENAL
- ☐ 500 BLADDER DISTURBANCES
 - ☐ 501 CALCIUM OXALATE STONES
 - ☐ 502 CALCIUM PHOSPHATE STONES

- ☐ 503 FREQUENT URINATION
- ☐ 504 GOUT
- ☐ 506 RENAL DISEASE

- NEUROLOGICAL
- ☐ 600 ALZHEIMER'S
 - ☐ 601 A.L.S.
 - ☐ 602 DYSLAXIA
 - ☐ 603 MULTIPLE SCLEROSIS
 - ☐ 604 MYESTHENIA GRAVIS
 - ☐ 605 PARKINSON'S DISEASE
 - ☐ 607 DEMENTIA
 - ☐ 609 STROKE
 - ☐ 611 TOURETTE'S SYNDROME

- EMOTIONAL
- ☐ 701 ANXIETY
 - ☐ 702 ATTENTION DEFICIT
 - ☐ 703 AUTISM
 - ☐ 704 DEPRESSION
 - ☐ 705 HOSTILITY
 - ☐ 706 LEARNING DISABILITY
 - ☐ 707 MEMORY LOSS
 - ☐ 708 SCHIZOPHRENIA
 - ☐ 710 MANIC DEPRESSION

ENDOCRINE

- ☐ 801 HYPERADRENIA
- ☐ 802 HYPERPARATHYROID
- ☐ 803 HYPERTHYROID
- ☐ 804 HYPOADRENIA
- ☐ 805 HYPOPARATHYROID
- ☐ 806 HYPOTHYROID

MALE

- ☐ 901 IMPOTENCE
- ☐ 902 PROSTATE CANCER
- ☐ 903 PROSTATE ENLARGEMENT
- ☐ 904 PROSTATITIS

FEMALE

- ☐ 1001 AMMENORRHEA
- ☐ 1002 BREAST TUMORS (BENIGN)
- ☐ 1003 BREAST TUMORS (MALIGNANT)
- ☐ 1004 MENSTRUAL BREAST SORENESS
- ☐ 1005 MENSTRUAL CRAMPS
- ☐ 1006 MENSTRUAL IRREGULARITY
- ☐ 1007 PROLONGED MENST. FLOW
- ☐ 1008 DECREASED MENST. FLOW
- ☐ 1009 PREMENSTRUAL SYNDROME
- ☐ 1011 FIBROCYSTIC DISEASE
- ☐ 1013 ENDOMETRIOSIS
- ☐ 1014 OVARIAN CYSTS

PROFILE AND LANGUAGE REQUESTED
To Avoid Processing Delays Check Profile Desired

- ☐ Profile 1: Test Results Only
- ☐ Profile 2: Test Results, Patient Report, Doctor Report, Dietary and Supplement Recommendations
- ☐ Profile 3: (For Retest Only) Test Results, Patient Report, Dietary and Supplement Recommendations

- ☐ Profile 4: Test Results and Patient Report Only
- ☐ Profile _____ (Specify either Profile 5, 6, 10 or 16)
(Please refer to Service Brochure for further Details)

LANGUAGE: _____

LABORATORY PAYMENT PLAN

☐ Prepay With Check No.: _____

M/V _____

☐ Bill To My Account: _____

Expires: _____

☐ Send C.O.D.

SUPPLEMENT REQUEST

☐ No Supplements Requested ☐ One Month Supply ☐ Two Month Supply ☐ Three Month Supply

SUPPLEMENT PAYMENT PLAN

☐ Prepay With Check No.: _____

M/V _____

☐ Bill To My Account: _____

Expires: _____

☐ Send C.O.D.

COMMENTS

FORM MUST BE COMPLETED IN ENTIRETY BY HEALTH CARE PROVIDER. FAILURE TO DO SO MAY RESULT IN PROCESSING DELAYS.

I understand that the interpretation or other information derived from the trace mineral analysis of the patient's hair, and the recommendations if implemented, will be based entirely upon my professional judgement and knowledge of the patient involved.

I also hereby certify that the above information provided by this office is complete and accurate to the best of my knowledge.

Leave highlighted
sections blank

PHYSICIAN/CLINICIAN

DATE