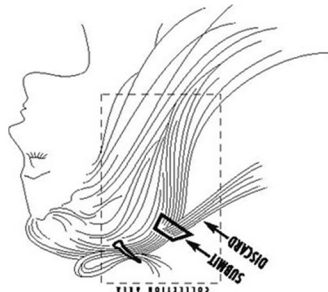


Fold 1
Fold 2
Fold 3

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.: _____

☐ Add Boron (only if purchased)**TMA SUBMITTAL FORM**

(PLEASE PRINT)

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. _____

SAMPLES SHOULD NOT BE OBTAINED FROM HAIR THAT WAS PERMED, COLORED OR CHEMICALLY TREATED IN THE PAST SIX (6) WEEKS.

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

Expires: _____

☐ Bill To My Account: _____☐ 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 _____

Expires: _____

☐ Bill To My Account: _____☐ 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.

PHYSICIAN/CLINICIAN

DATE

Leave highlighted sections blank