Longevity NUTRICARE
Where Health Gets Perfected

Longevity NutriCare LLC
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Longevity Test Information Form

1. PATIENT INFORMATION			2. ORDERING PROVIDER INFORMATION		
First Name	Last Name		First Name	Last Name	
Date of Birth	☐ Male ☐ Female	Age	Medical Credentials	NPI	
Address			Facility Name		
City	State	Zip Code	Address		
Phone			City	State	Zip Code
Email			Phone	Email	

3. SPECIMEN INFORMATION

Date of Collection	Fasting ☐ YES ☐ NO	Collected By
Time of Collection		

Specimen Type ☐ SST ☐ Lavender ☐ Lt. Blue ☐ Gray ☐ Yellow ☐ Green ☐ Red ☐ Buccal ☐ Saliva ☐ Urine

4. LONGEVITY TESTS REQUESTED

☐ LONGEVITY SIGNATURE BLOOD TEST	☐ LONGEVITY HORMONE	☐ LONGEVITY MICRONUTRIENTS	☐ LONGEVITY INFLAMMATION	☐ LONGEVITY OXIDATIVE STRESS
☐ LONGEVITY BRAIN GLIAL	☐ LONGEVITY ALZHEIMER'S	☐ LONGEVITY MITOCHRONDRIA	☐ LONGEVITY HEART	☐ LONGEVITY DIABETES
☐ LONGEVITY MEN'S HEALTH	☐ LONGEVITY CANCER	☐ LONGEVITY GUT	☐ LONGEVITY SLEEP	☐ LONGEVITY WEIGHT LOSS
LONGEVITY INDIVIDUAL TESTS:	☐ KLOTHO	☐ BDNF	☐ AMYLOID BETA 42	☐ OTHER TESTS

5. MENTAL HEALTH TESTS REQUESTED

☐ KYNURENINE PATHWAY BLOOD TEST	☐ KYNURENINE PATHWAY NEUROINFLAMMATION BLOOD TEST
☐ KYNURENINE PATHWAY METHYLATION BLOOD & DNA TEST	☐ KYNURENINE PATHWAY MOOD DISORDER BLOOD TEST
☐ KYNURENINE PATHWAY SEROTONIN SYNTHESIS BLOOD TEST	☐ KYNURENINE PATHWAY SLEEP BLOOD TEST

6. INTELLIMIND TESTS REQUESTED

☐ IntelliMIND AUTISM & ADHD BLOOD TEST	☐ IntelliMIND METHYLATION DNA TEST
☐ IntelliMIND METHYLATION BLOOD TEST	☐ IntelliMIND FOLATE RECEPTOR AUTOANTIBODIES IGG BLOOD TEST
☐ IntelliMIND SLEEP SALIVA TEST	☐ OTHER TESTS

7. PATIENT INFORMED CONSENT

By signing below, I, the patient, give permission to Longevity NutriCare LLC to perform laboratory testing as described. I voluntarily consent to testing. I understand that I am responsible for all costs of testing. I understand that testing not performed by this laboratory will be forwarded to another accredited reference laboratory. This specimen was provided voluntarily for analysis, and I authorize Longevity NutriCare LLC to process, bill and provide results.

Patient Signature: ______________________________ **Date:** ______________________

8. CONFIRMATION OF INFORMED CONSENT

I attest that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Longevity NutriCare LLC Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

Ordering Provider Signature: ______________________________ Date: ______________________