neurozym

For Neurozym Biotech AS

TEST REQUEST FORM

PATIENT DATA

Name

Date of birth (dd mm yy)

E-mail

PHYSICIAN/THERAPIST

Name

E-mail

ADDRESS FOR SENDING TEST RESULTS

Recipient's name

Write post address here

Country

INFORMATION ABOUT SAMPLING

Date and time of sampling

Have the sample been frozen? ☐ Yes ☐ No

MEDICATION

Is the patient on medication? (IMPORTANT) ☐ Yes ☐ No

Write medication and dosage here

INFO. ON FOOD INTAKE BEFORE SAMPLING

Time of last food intake before sampling

Contained meal gluten (bread products) ☐ Yes ☐ No

Contained meal casein (milk products) ☐ Yes ☐ No

DIAGNOSIS/CLINICAL INFORMATION

Write diagnosis and symptoms here

PAYMENT **Payment is due at SWIFT transfer to Neurozym account. Invoice will be sent to the customer**

Payer`s name and address for sending the invoice:

Name

Post address or email address

Country

Price analysis:

105 Euro for customers in Europe

This form should NOT be used by costomers in Norway

Neurozym Biotech AS · Murbraek · 7760 Snaasa · NORWAY ·Tel +47 74 15 15 00 · Fax +47 74 15 16 40
Org.nr: NO 961 251 273 MVA · post@neurozym.com · www.neurozym.com