



TMA SUBMITTAL FORM (PLEASE PRINT)

LAB ID. NUMBER

Please provide previous laboratory number if applicable.

Account No: 1651
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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 [] AXILARY
[] 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:

DYES

SUBMITTED BY

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

Email address:

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 129 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 ARTERIOSCLEROSIS 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 DYSLLEXIA 603 MULTIPLE SCLEROSIS 604 MYESTHENIA GRAVIS 605 PARKINSON'S DISEASE 607 DEMENTIA 609 STROKE 611 TOURETTE'S SYNDROME 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 M/V Expires: Prepay With Check No.: 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 M/V Expires: Prepay With Check No.: 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

I understand that my card will be charged \$85 by Trace Elements, Inc.

Credit Card No:

Expiry date:

Security no (3-digits on back of card):