



## ARMIN LABS TEST ORDER FORM

Last and first name of patient:		BARCO DE (Lab)	Send results to: Myself
			My Physician
			Name of Practitioner and Clinic:
Male	Female		Name of Practice:
Date of Birth (DD/MM/YYYY):			Street/House Number:
		Time of Blood Draw:	Street/House Number:
Street/House Number:		Date (DD/MM):	Address:
Address:		Material/Quantity CPDA	Address:
		Heparin EDTA	City: Postcode:
City: Postcode:			City: Postcode:
Tel no:		Serum	Tel no:

See overleaf for list of tests. Once the relevant tests have been selected, please do the following:

Please enter the tests (numbers) you wish to order: \_\_\_\_\_

Please calculate the total amount to be paid for the tests: \_\_\_\_\_

Add £30 for FedEx courier delivery: Total: \_\_\_\_\_

If you would like to pay by bank transfer, please use the following details:

**Bank:** Barclays Bank, 28 Chesterton Road, Cambridge CB4 3EZ, UK  
**A/C name:** Academy Of Nutritional Medicine (AONM)  
**Sort code:** 20-17-22 **Account number:** 63880265  
**IBAN:** GB82 BARC 2017 2263 8802 65 **SWIFT/BIC:** BARCGB22

If you would like to pay by credit card, please call the AONM helpline to make the payment. Once the payment is confirmed, AONM will send you an authorisation code by email, or give it to you over the phone. Please insert it in the box below:

**AONM Authorisation Code**

**Data Protection. Consent to data transfer and discharge from the duty of (medical) confidentiality.** I hereby give my consent for my personal data and treatment data to be collected, stored, processed and used. I also agree that my data, which are necessary for invoice processing (e.g. name, date of birth, address, date of treatment, service codes, invoice sums, treatment documentation) will be disclosed to "Academy of Nutritional Medicine (AONM), St. John's Innovation Centre, Cowley Road, Cambridge CB4 0WS" and "ArminLabs, Zirbelstrasse 58. 2<sup>nd</sup> floor, 86154 Augsburg, Germany for the purpose of the creation of invoices or for collection of receivables or – if necessary – for judicial enforcement. This declaration of consent can be revoked at any time with effect for the future. In this respect I release my treating practitioner, AONM and ArminLabs and their employees from their obligation of (medical) secrecy. I also agree that the laboratory results, which are obtained within the scope of this laboratory order, will be disclosed to my treating practitioner.

Please sign below to say that you agree with the above:

Date, signature:

\_\_\_\_\_

