

DOCTORS DATA HEAVY METAL TEST INSTRUCTIONS

SAVE THIS BOX FOR SHIPPING YOUR TEST SAMPLE TO THE LAB!

Before the Test: Read the directions and familiarize yourself with the procedures. Wait at least 2 weeks following a detoxification program before retesting.

Verify Kit Contents:

- 1 white specimen collection cup
- 1 small screw-cap vial
- 1 zip-lock bag with absorbent material
- 1 Laboratory Requisition Form
- 8 DMPS capsules (25 mg each, total 200 mg)
- 1 prepaid FedEx Shipping Pack & Label

NOT FOR USE IF PREGNANT OR UNDER 18 YEARS OF AGE WITHOUT PHYSICIAN DIRECTION.

For child testing instructions, email customercare@mercout.com.

This test uses DMPS; if you are not familiar with it, please read the FAQ section on our website at www.MercOut.com.

You will be shipping your sample to an independent laboratory for analysis; results are sent by the lab to the MercOut medical director for evaluation, then emailed to you or your referring clinician.

Before the Test:

- Do not take the test during a menstrual cycle.
- For 2 days before the test, avoid all seafood and fish oil supplements.
- On the day before the test, drink about 6–8 glasses of water to stay well hydrated.
- Check off: "Bill Physician" on the requisition form.

On the Day of the Test:

- This is a **2-hour heavy metal test** to be completed first thing in the morning.
- Avoid mineral supplements and food for at least 2 hours before the test.
- Empty your bladder **do not collect this urine.**

On an empty stomach with 8 oz. of water, take DMPS as follows:

8 capsules (25 mg each) if you weigh over 120 lbs (>54 kilos)

- 6 capsules if you weigh up to 120 lbs (<54 kilos)
- 4 capsules for children 30–60 lbs (13–27 kilos)
- 2 capsules for children under 30 lbs (<13 kilos) Not recommended for children under 2 years of age.
- You may eat 30 minutes after taking the DMPS capsules.
- The test will take 2 hours; drink \sim 32 oz. of water during this time to ensure urine production.
- Retain urine in your bladder for the full 2 hours, then collect the first urine in the provided collection cup (fill at least halfway).
- If after 2 hours you haven't urinated enough, drink another 32 oz. of water. It's okay if the test takes longer than 2 hours — just **not less** than 2 hours.

TIP: If you can't hold your urine for the full 2 hours, collect all urine during that time in a clean container, then pour into the vial.

To Process the Collected Specimen:

- Pour the urine into the screw-top transport bottle and close tightly. Discard any extra urine.
- Write your name and date of collection on the bottle; check the box marked "Post."
- Place the vial in the zip-lock bag with absorbent material and seal it.
- Place the bag and the **completed requisition form** in the original shipping box.

To Ship the Collected Specimen:

- Place the box in the prepaid FedEx envelope and seal.
- FedEx shipping is prepaid only within the U.S. and Canada.
- Keep the FedEx tracking number for your records.

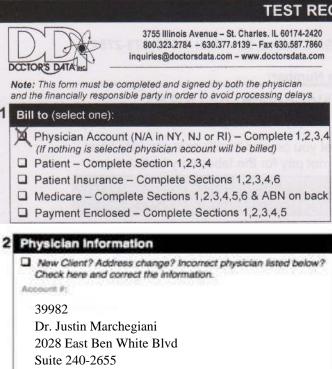
U.S. Clients:

- Write your name/address on the prepaid Billable Stamp.
- Call FedEx at 1-800-238-5355 to schedule a pickup. Say "REP" at the prompt, then say "YES" when asked if shipping a package. Say you are using a prepaid "Billable Stamp."

Canadian Clients:

- Fill out the Air Waybill and sign it.
- Fill out the shaded areas of the commercial invoice and sign it.
- Insert both into the adhesive pouch and affix it to the FedEx Clinical Pak.
- Call FedEx at 1-800-463-3339. Say "REP" at the prompt, then "YES" when asked if shipping. Request a Third Party Pickup using "Air Waybill with account number 185197611."

TEST REQUISITION FORM



Medicare will pay only for tests that meet the Medicare coverage

criteria and are reasonable and necessary to create or diagnose an

individual patient. Medicare does not pay for tests for which docum-

entation, including the patient record, does not support that the tests

were reasonable and necessary. Medicare generally does not cover routine screening tests even if the physician or other authorized test

orderer considers the tests appropriate for the patient. Your ordering

of the test(s) means that you believe the test(s) is medically

Date Ordered:

Test(s) Ordered Medicare patients see reverse side for important information. For Insurance/Medicare provide ICD-9 diagnosis codes for each test ordered. Urine Toxic Metals profile Collection Information: → Date final sample was collected: 6 Pt. Weight (lb.):_ → Pt. Height (in.): Random - First morning void recommended (→ Collection Period: ☐ Less than 24 hours - Number of hours:__ ☐ 24 hours - Volume (mL):_____ → If this sample is part of a provocative challenge; is it □ pre or □ post? → Provoking agent: DMPS 500 mg _Dosage:_ CPT: ICD-9 Diagnosis Codes (required): Profile components: 82108 Aluminum Arsenic 82175 Heavy Metals* 83018 * Includes: Antimony, Barium, Beryllium, Bismuth, Cesium, Gadolinium, Palladium, Platinum, Tellurium, Thallium, Thorium, Tin, Tungsten, Uranium 82300 83655 83825 Mercury 83885 Nickel AVAILABLE ADD-ON TESTS: (additional fees apply): 84999 ☐ Urine lodine Urine Halldes (I, Br & F) MULTIPLE ☐ Urine Essential Elements MULTIPLE 82575 Creatinine Clearance Timed Urine (24 hr preferred) with volume + serum sample required for Creatinine Clearance. Serum must be drawn during urine collection period. → Urine Collection Volume (mL): Hours collected: → lodine Loading Dose:

Medicare Patients read and sign ABN on back of form.

Patient Information Patient / responsible party is financially responsible for any portion of the claim not covered by insurance within 30 days.			
Patient Name:	Patient Date of Birth://	Sex:	
Mailing Address:	- The State of the		
City: _	State: County (required for NY):	Zip:	
Daytime Phone: () Evening Phone:	() Patient Social So	ecurity #:	
Responsible Party Name:	Responsible Party Social Se	ecurity #:	
Responsible Party Date of Birth:// Relationship	o to Patient: Self Spouse Parent Othe	er	
Mailing Address:			
City:	State:	Zip:	

THIS SPACE FOR LAB USE ONLY

X (Required)

Austin TX 78741

X (Required)

Physician Signature: Justi Marchey

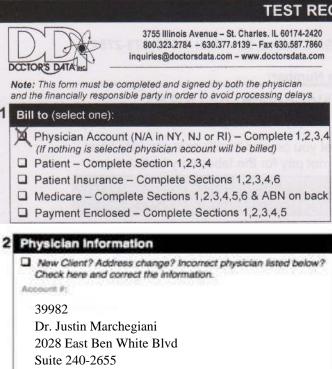




Date:

V01.12

TEST REQUISITION FORM



Medicare will pay only for tests that meet the Medicare coverage

criteria and are reasonable and necessary to create or diagnose an

individual patient. Medicare does not pay for tests for which docum-

entation, including the patient record, does not support that the tests

were reasonable and necessary. Medicare generally does not cover routine screening tests even if the physician or other authorized test

orderer considers the tests appropriate for the patient. Your ordering

of the test(s) means that you believe the test(s) is medically

Date Ordered:

Test(s) Ordered Medicare patients see reverse side for important information. For Insurance/Medicare provide ICD-9 diagnosis codes for each test ordered. Urine Toxic Metals profile Collection Information: → Date final sample was collected: 6 Pt. Weight (lb.):_ → Pt. Height (in.): Random - First morning void recommended (→ Collection Period: ☐ Less than 24 hours - Number of hours:__ ☐ 24 hours - Volume (mL):_____ → If this sample is part of a provocative challenge; is it □ pre or □ post? → Provoking agent: DMPS 500 mg _Dosage:_ CPT: ICD-9 Diagnosis Codes (required): Profile components: 82108 Aluminum Arsenic 82175 Heavy Metals* 83018 * Includes: Antimony, Barium, Beryllium, Bismuth, Cesium, Gadolinium, Palladium, Platinum, Tellurium, Thallium, Thorium, Tin, Tungsten, Uranium 82300 83655 83825 Mercury 83885 Nickel AVAILABLE ADD-ON TESTS: (additional fees apply): 84999 ☐ Urine lodine Urine Halldes (I, Br & F) MULTIPLE ☐ Urine Essential Elements MULTIPLE 82575 Creatinine Clearance Timed Urine (24 hr preferred) with volume + serum sample required for Creatinine Clearance. Serum must be drawn during urine collection period. → Urine Collection Volume (mL): Hours collected: → lodine Loading Dose:

Medicare Patients read and sign ABN on back of form.

Patient Information Patient / responsible party is financially responsible for any portion of the claim not covered by insurance within 30 days.			
Patient Name:	Patient Date of Birth://	Sex:	
Mailing Address:	- The State of the		
City: _	State: County (required for NY):	Zip:	
Daytime Phone: () Evening Phone:	() Patient Social So	ecurity #:	
Responsible Party Name:	Responsible Party Social Se	ecurity #:	
Responsible Party Date of Birth:// Relationship	o to Patient: Self Spouse Parent Othe	er	
Mailing Address:			
City:	State:	Zip:	

THIS SPACE FOR LAB USE ONLY

X (Required)

Austin TX 78741

X (Required)

Physician Signature: Justi Marchey





Date:

V01.12