



Great Plains Lab Test Instructions for the Organic Acid test

What you should receive:

1. Pre-paid FedEx envelope to send the lab test back. Please take note of the shipping/tracking number if you would like to track the package.
2. Instructions on how to conduct the test.
3. Sample collection container.

What you need to do to complete the Organic Acid test:

1. Please fill out the attached requisition form with all the required information.
2. You **MUST** include the date and time the sample was taken.
3. Please discard the blank requisition form that came with the kit. Replace with the completed requisition form in the current document.
4. Avoid apples, grapes, raisins, and cranberries for 24 hours before the test.
5. Avoid all nutrient supplements consisting of vitamins, minerals and amino acids 24 hours before the test. Hormones or hormone precursor support i.e. Pregnenalone and DHEA are ok.
6. Follow the instruction in the lab kit regarding the urine collection.
7. Double check that the completed requisition form has been included before shipping.

What you need to do next:

1. Dr Justin will go over your lab results with you as soon as they are in. We typically receive results within 2-3 weeks.
2. Make sure you have an appointment scheduled with Dr Justin to review the results.
3. If you have any questions, please call Customer Service at 913-341-8949 or email CustomerService@gp-labs.com



The Great Plains Laboratory, Inc.

Help us expedite your test(s) at www.gpltestinfo.com. Reference #: _____

Information in red is required to process sample.

Test Requisition Form

Must fill out test orders on the reverse side

Patient Information (please print clearly)

First Name	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY)	Age	Weight
Address	City	State (NY not accepted)	Zip Code	Country	
Phone	Email				

Our laboratory does NOT accept specimens from patients who reside in or practitioners who practice in the state of New York.

Practitioner Information (signature required to process sample)

First Name	Last Name	Credentials		
Institution	Phone	Fax		
Address	City	State (NY not accepted)	Zip Code	Country
Email	NPI			
Signature	<input type="checkbox"/> Practitioner Signature on File	Carevoyant ID (GPL Account Number)		

Method of Payment

- ☐ **Bill Practitioner** Practitioner's Name: _____
Unavailable for practitioners that reside in the states of New Jersey, Rhode Island and New York.
- ☐ **Bill Insurance** Non-Contracted insurance plans must enclose 50% insurance pre-payment (see price list).
Refer to Insurance Overview to determine whether you have a contracted or non-contracted insurance plan.
For questions, call 913-754-0459. Complete payment information below for Insurance Pre-Payment.

Patient Pay (select payment method below)

- ☐ Pay online at www.greatplainslaboratory.com/payments Transaction ID# _____
- ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover ☐ Money Order Amount \$ _____
Card # _____ Exp. Date _____ Security Code _____
Name on Card _____ Signature _____

ICD-10 Codes

Required for insurance:

- 1 - _____
2 - _____
3 - _____
4 - _____
5 - _____

Internal Use Only:

Person Responsible for Charges

☒ Same as patient

First Name	Last Name	Home Phone		
Email	Cell Phone			
Address	City	State/Province	Zip Code	Country

Primary Insurance (include photocopy of both sides of insurance card)

For Medicare and Medicare Advantage, Advance Beneficiary Notice of Noncoverage (ABN) Form must be completed.

Company & Plan Name (ex. BCBS of Kansas City)	Company & Plan Name (ex. BCBS of Kansas City)
Insurance Company Address	Insurance Company Address
Insurance Company Phone (required)	Insurance Company Phone (required)
Name of Insured <input type="checkbox"/> Male <input type="checkbox"/> Female	Name of Insured <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth of Insured (MM/DD/YYYY)	Date of Birth of Insured (MM/DD/YYYY)
Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Subscriber Number	Subscriber Number
Group Number	Group Number

Authorization of Testing, Acknowledgement of Insurance Procedures and Agreement to Cancellation Policy

I authorize and request payment of medical benefits be made directly to The Great Plains Laboratory, Inc. (GPL) for the requested lab work. I authorize the release of any medical information necessary to process this claim. I understand that any reimbursement checks and explanation of benefits (EOBs) received by the patient must be submitted to GPL. I understand that certain tests are not billable to insurance (self-pay tests) and may not be covered by my insurance plan. Person responsible for charges authorizes GPL to process payment in full for these tests. I agree to be fully responsible for any portion of the claim not covered by my insurance and make payment within 30 days. I understand that a service charge of 1.5% per month may be charged on balances over 30 days. I permit a copy of this to be used in place of the original. Cancellation Policy: I have reviewed and agree to the cancellation policy located at www.greatplainslaboratory.com/cancellation-policy.

Patient/Guarantor Signature _____ Date (MM/DD/YYYY) _____



Specimen date and time of collection

URINE Collection Date (MM/DD/YYYY): _____

BLOOD Collection Date (MM/DD/YYYY): _____

STOOL 1 Collection Date (MM/DD/YYYY): _____ Collection Time: _____ ☐ AM ☐ PM

STOOL 2 Collection Date (MM/DD/YYYY): _____ Collection Time: _____ ☐ AM ☐ PM

SALIVA Collection Date (MM/DD/YYYY): _____

HAIR Collection Date (MM/DD/YYYY): _____

Dried Blood Spot (DBS) Collection Date (MM/DD/YYYY): _____

HORMONES TEST ONLY

Collection Date (MM/DD/YYYY): _____ Collection Time: Morning _____ Noon _____ Evening _____ Night _____

Sample frozen? ☐ Yes ☐ No

Check any applicable: ☐ Hysterectomy ☐ Ovaries removed First Day of Last Menstrual Period (MM/DD/YYYY): _____

Has urine been frozen? ☐ Yes ☐ No

Date of collection required for ALL specimen types.

Time of collection required for stool and hormone samples.

STOP

Urine

- ☐ Organic Acids Test (OAT) (76)
- ☐ MycoTOX Profile* (Mold Exposure) (11)
 - ☐ Check if patient is taking mycophenolate mofetil (CellCept/Myfortic)
- ☐ Glyphosate Test*
- ☐ GPL-TOX Profile* (173 Toxic Non-Metal Chemicals) (18)
- ☐ Microbial Organic Acids Test* (MOAT) (21) (included in OAT)
- ☐ Amino Acids Test* (43) ☐ Random Collect ☐ 24 Hr Total vol _____ mL
- ☐ Calcium + Magnesium Test*
- ☐ Metals Urine Test (38) Select type of collection:
 - ☐ Random ☐ 24 Hour Total vol. _____ mL
 - ☐ Timed # of hrs _____ Total vol. _____ mL
 - ☐ Pre-Provoking ☐ Post-Provoking agent _____ Dosage _____

Stool

- ☐ Comprehensive Stool Analysis x2
- ☐ Metals Fecal Test (13)
 - ☐ Pre-Provoking ☐ Post-Provoking agent _____ Dosage _____
- Does patient have dental amalgams? ☐ No ☐ Yes – How many? _____
- ☐ Microbiology Test

Blood (Serum, RBC, Whole Blood)

- ☐ IgG Food MAP with *Candida* + Yeast (192) (Serum)
- ☐ Mold IgE Allergy Test (Serum)
- ☐ IgE Allergy Advanced Combined (93 foods & 69 inhalants) (Serum)
- ☐ IgE Food Allergy Basic Test (25) (Serum)
- ☐ IgE Food Allergy Advanced Test (93) (Serum)
- ☐ IgE Inhalant Allergy Basic Test (36) (Serum)
- ☐ IgE Inhalant Allergy Advanced Test (69) (Serum)
- ☐ Metals Test: ☐ Whole Blood (20) ☐ Red Blood Cell (18)
- ☐ Advanced Cholesterol Profile (Serum)
- ☐ Amino Acids Plasma Test* (43) (requires overnight fast)
- ☐ Copper + Zinc Profile (Serum)
- ☐ Dipeptidyl Peptidase IV (DPP-IV) Test* (Serum)
- ☐ Homocysteine Test* (Serum)
- ☐ Iron + Total Iron-Binding Capacity Test (TIBC)* (Serum)
- ☐ Streptococcus Antibodies Profile (Serum)
- ☐ Vitamin D Test (Serum)

Hair

- ☐ Metals Hair Test (39)

Combo and Test Panels

Extra charges may apply for combos/panels that DO NOT arrive in same FedEx bag.

- ☐ **Autism Panel** (Adv. Cholesterol, Comp Stool Analysis, Glyphosate*, GPL-TOX*, IgG Food MAP, Metals Hair, OAT, Omega-3 Index Complete*)
- ☐ **ADHD Panel** (Organic Acids, GPL-TOX*, Glyphosate*, IgG Food MAP, Metals Hair, Omega-3*)
- ☐ **ENVIROtox Panel** (GPL-TOX*, OAT, Glyphosate*)
- ☐ **ENVIROtox Complete Panel** (ENVIROtox Panel + MycoTOX*)
 - ☐ Check if patient is taking mycophenolate mofetil (CellCept/Myfortic)
- ☐ **Fibromyalgia Panel** (OAT, GPL-TOX*, Glyphosate*, IgG Food MAP, Metals Hair, Omega-3*)
- ☐ **Functional Allergy and Nutrition Panel (FAN)** (IgG Food MAP – Serum, Iron + Total Iron-Binding Capacity (TIBC)*, DPP-IV*, Homocysteine*)
- ☐ **GPL Basic DBS** (OAT, GPL-TOX*, Glyphosate*, IgG Food MAP, Metals Hair, Omega-3*)
- ☐ **GPL Basic Serum** (OAT, GPL-TOX*, Glyphosate*, IgG Food MAP, Metals RBC)
- ☐ **GPL Complete** (OAT, GPL-TOX*, Glyphosate*, IgG Food MAP, Cholesterol, Comp Stool, Copper + Zinc, Ferritin, Metals Hair, Vitamin D)
- ☐ **GPL3 – DBS** (OAT, Metals Hair, IgG Food)
- ☐ **GPL3 – Serum** (OAT, Metals RBC, IgG Food)
- ☐ **Mental Health Panel** (OAT, GPL-TOX*, Glyphosate*, IgG Food, Amino Acids Plasma, Metals Hair, Omega-3*)
- ☐ **Mold IgE Allergy Test + MycoTOX Combo**

Dried Blood Spot

- ☐ IgG Food MAP with *Candida* + Yeast (192)
- ☐ Omega-3 Index Complete* (DBS One-Spot Card)
- ☐ Vitamin D Test

Saliva

- ☐ DNA Methylation Pathway Profile* (requires Informed Consent form)
- ☐ Hormones Comprehensive Plus Panel
Estrone, Estradiol, Estriol, Progesterone, Testosterone, DHEA, 4x Cortisol
- ☐ Hormones Comprehensive Panel
Estradiol, Progesterone, Testosterone, DHEA, 4x Cortisol

Other

☐ _____

May we use your test data for research purposes?

☐ Yes ☐ No NO IDENTIFYING INFORMATION WILL BE RELEASED

If yes, please check boxes applicable to this patient.

- ☐ ADD/ADHD ☐ Alzheimer's ☐ Asperger's
- ☐ Autism Spectrum Disorders ☐ Chronic fatigue ☐ Colitis
- ☐ Crohn's disease ☐ Depression ☐ Down syndrome
- ☐ Fibromyalgia ☐ Irritable bowel ☐ Multiple sclerosis ☐ OCD
- ☐ PDD ☐ Psychosis ☐ Schizophrenia ☐ Tourette's/Tics
- ☐ Other (please list): _____

Signature: _____

* denotes that the test is not billable to insurance






11813 West 77th Street, Lenexa, KS 66214 | (913) 341-8949 | Fax: (913) 341-6207 | GP-Labs.com

AMINO ACIDS TESTING WARNING: Vial contains approximately 120 mg of oxalic acid. KEEP OUT OF REACH OF SMALL CHILDREN.**DO NOT INGEST OR INHALE.** Wipe spills with a wet towel. In case of contact with skin, wash with soap and plenty of water. In case of accidental contact to eye or ingestion, rinse with plenty of water. Seek medical attention if warranted.

Before You Begin Collections

1. Save the cardboard box and place the gel pack flat into the freezer (for at least 4 hours) to ship the sample back to us.
2. Samples may only be sent off to the lab **Monday through Thursday**. If samples are sent a different day, the sample may become compromised.
3. Please check the specimen requirements below for patient preparation instructions.
4. Only use containers supplied by GPL to avoid contamination of specimens.
5. Fill out the Test Requisition Form completely. Please **PRINT** clearly. For US patients, a physician authorization is required.
6. Females, please do not collect samples during menstrual cycle.
7. Limit liquid intake starting at 6pm the night prior to collection to avoid sample dilution. Urine must be yellow in color, if urine is clear the sample is too diluted. Discard diluted sample, rinse collection cup in hot water only (no soap), air dry, then re-collect.
8. If you have any questions, please call Customer Service at (913) 341-8949 or email CustomerService@gp-labs.com.



Test	Min.	Items to Discontinue	Urine Collection	After Collection
Amino Acids Urine Test 	25 mL Urine	Discontinue any amino acid supplements 48 hours prior to collection. The test requires no special diet but if you are taking antibiotic medications, please finish the course of medication, and then wait 48 hours before starting collection. <i>Never discontinue prescription medications without first consulting your physician.</i>	Collect the first morning urine in the collection cup provided. Collecting sample prior to eating or drinking is preferred.	Pour some of the urine into the white specimen vial to the fill line – do not underfill, make sure to leave at least 5 mL remaining in collection cup. Secure lids tightly on both the collection cup and specimen vial. Invert vial 5 times to mix urine with the preservative. Freeze both cup and vial until ready to ship. Ship vial and cup with frozen gel pack.
Organic Acids + Amino Acids Combo Test 	35 mL Urine	Avoid apples, grapes, pears, and cranberries as well as their juices or products 48 hours before collection. Avoid arabinogalactan, echinacea, reishi mushrooms, ribose supplements, and any amino acid supplement for 48 hours before collection. The test requires no special diet but if you are taking antibiotic medications, please finish the course of medication, and then wait 48 hours before starting collection. <i>Never discontinue prescription medications without first consulting your physician.</i>	Collect the first morning urine in the collection cup provided. Collecting sample prior to eating or drinking is preferred.	Pour some of the urine into the white specimen vial to the fill line – do not underfill, make sure to leave at least 10 mL remaining in collection cup. Secure lids tightly on both the collection cup and specimen vial. Invert vial 5 times to mix urine with the preservative. Freeze both cup and vial until ready to ship. Ship vial and cup with frozen gel pack.
Amino Acid 24 Hour Urine  Orange Collection Container (do not return)	50 mL Urine	Discontinue any amino acid supplements 48 hours prior to collection. The test requires no special diet but if you are taking antibiotic medications, please finish the course of medication, and then wait 48 hours before starting collection. <i>Never discontinue prescription medications without first consulting your physician.</i>	Begin by collecting the 2nd urination of the day. Urinate into the large orange collection container. Do not return the orange container. Continue collecting urine for 24 hours, including the first urination of the next morning. Keep urine refrigerated in between voids.	Mix the urine in the large container. Record the TOTAL VOLUME on the Test Requisition Form. Failure to record the total volume may skew test results. Pour urine into the white-topped vial to the fill line – DO NOT underfill. Pour 5mL of urine into the yellow-top collection cup. Screw lids tightly on both the cup and vial. Invert vial 5 times to mix urine with the preservative. Freeze both the cup and vial until ready to ship. Ship the cup and vial with the frozen gel pack. DO NOT ship the large collection container.

Preparing and Shipping Specimens

1. Fill out the Test Requisition Form (TRF). Please PRINT clearly.
2. Print the patient's full name, time and collection date on the side of the urine cup (and other pour off vials as provided).
3. Place urine specimen(s) into the biohazard zip-lock bag along with the absorbent packing sheet. Place frozen gel pack and urine sample(s) into the silver thermo bag. Place the silver thermo bag into the cardboard box (UPS may reject package if sample is not in box). Fold and place the completed TRF in the box and close the lid. Place the box in the UPS Laboratory Pak and seal using the adhesive strip.
4. Please take note of the shipping/tracking number if you would like to track the package.
5. For best results, samples should be taken to your local UPS location (preferably toward end of the day to ensure sample(s) remain frozen during transit). To find your closest UPS Store location and hours visit www.ups.com/dropoff. Alternatively, you may call for a UPS pickup at 1 (800) 742-5877 and advise them you need to schedule a pick-up using a return label. Do not put kit(s) in a UPS drop box due to extended periods of time in a drop box can lead to errors in test results.
6. PLEASE DO NOT ISSUE DIRECT PAYMENT TO UPS for the shipment. If UPS attempts to bill you for shipping costs, please contact our staff for assistance at 913-341-8949. The Great Plains Laboratory is unable to reimburse shipping charges in cases where UPS is paid directly.

Turn Around Time

Please note that most test results take a minimum of **two weeks** to become available after the sample arrives at our facility.