Dr. Justin Marchegiani – www.JustInHealth.com - Office@JustInHealth.com – Office (512) 535-1817– Fax (707) 227-1529

Just In Health
Wellness Clinic

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 zip-lock bag with absorbent material
1 DMPS capsule 125 mg capsules
1 small screw-cap vial
1 Laboratory Requisition Form
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 web site 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 so you are well hydrated
- **Check off: "Bill Physician"**

On the Day of the test:

- **This is a 2-hour heavy metal test – Complete when you wake up 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:
  ALL 4 CAPSULES if you weigh **OVER 120 lbs. (>54 kilos)**
  3 CAPSULES of DMPS if you weigh **up to 120 lbs. (<54 kilos)**
  2 CAPSULES for CHILDREN **30-60 lbs**. **(13-27 kilos)**
  1 CAPSULE for CHILDREN **under 30 lbs**. **(<13 kilos) NOT RECOMMENDED FOR CHILD UNDER 2 YEARS**
- **You may eat 30 minutes after taking the DMPS capsules.**
- The test will take 2 hours; drink about 32 ounces of water during this 2-hour period so you can create urine.
- **Retain urine in bladder for at least 2 hours** and collect the first urine after that in the white collection cup provided, filling it about ½ full. If after 2 hours you still have no urge to urinate, or have not produced sufficient urine to fill the collection cup halfway, drink another 32 ounces, as you may be dehydrated. It is OK for the test to take longer than 2 hours, just not less than 2 hours.
- **If you can't hold it in your bladder for the 2 hours**, collect all urine produced during the 2 hours in a larger, clean container. You then will pour from this container into the screw-top specimen vial.
  TIP: Put a sign or the container on top of the toilet so you don't forget to collect the urine!

TO PROCESS THE COLLECTED SPECIMEN

- Pour the urine into the screw-top transport bottle and tighten the lid securely. Discard any remaining urine.
- Write your name and collection date on the bottle; check box that reads "Post." Place vial in the zip-lock bag with absorbent material and seal, then put in cardboard shipping box your test arrived in.
- On the **Laboratory Requisition Form** provided, fill in **Patient Name**, **Patient Date of Birth, Sex** and **Date Specimen Was Collected**. Place the completed form in the shipping box with the specimen.

TO SHIP THE COLLECTED SPECIMEN

Place the box containing your specimen in the FedEx mailing envelope and seal. **The FedEx shipment is pre-paid only if mailed in the U.S. or Canada. Outside these countries you must make your own shipping arrangements. Keep the FedEx receipt with tracking number for your records.**

US Clients: Write your name/address in the space provided on prepaid Billable Stamp. Call FedEx toll free **1-800-238-5355** Monday - Friday to schedule pickup. When you hear automated greeting, say "REP". When asked if you're shipping a package, reply "YES" to be connected to a live representative. Say you need pickup for a shipment using a prepaid "BILLABLE STAMP" and give your address.

Canadian Clients: Write your name/address in the space provided on Air Waybill (AWB) and sign at bottom. Tear off the shipper's copy of the AWB for your records. Fill out shaded areas of commercial invoice and sign at bottom. Put AWB and commercial invoice in adhesive pouch and affix pouch to Clinical Pak in space provided. Call FedEx toll free at **1-800-463-3339** to schedule pickup. When you hear automated greeting, say "REP". When asked if you're calling to ship a package, reply "YES" to be connected to live agent. Say you need a **Third Party Pickup** for shipment using **"Air Waybill with account number 185197611"** and give your address.

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No Saturday pickup. If you complete the collection on Saturday or Sunday, refrigerate specimen until you ship.
DO NOT USE A DROP BOX – FedEx will not accept test samples placed into a drop box.
Results take up to 10 BUSINESS DAYS to be emailed to you. Please be patient.

TEST REQUISITION FORM

DOCTOR'S DATA INC
3755 Illinois Avenue – St. Charles, IL 60174-2420
800.323.2784 – 630.377.8139 – Fax 630.587.7860
inquiries@doctorsdata.com – www.doctorsdata.com

Note: *This form must be completed and signed by both the physician and the financially responsible party in order to avoid processing delays.*

1 Bill to (select one):

- [X] Physician Account (N/A in NY, NJ or RI) – Complete 1,2,3,4
  (If nothing is selected physician account will be billed)
- [ ] Patient – Complete Section 1,2,3,4
- [ ] Patient Insurance – Complete Sections 1,2,3,4,6
- [ ] Medicare – Complete Sections 1,2,3,4,5,6 & ABN on back
- [ ] Payment Enclosed – Complete Sections 1,2,3,4,5

2 Physician Information

- [ ] *New Client? Address change? Incorrect physician listed below? Check here and correct the information.*

Account #: **39982**

Dr. Justin Marchegiani DC
512-535-1817

Physician Signature:

X *(Required)* _____ Date Ordered: 2-20-15

NPI # 1477828408

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 documentation, 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 necessary unless you indicate that it is for screening purposes.

3 Test(s) Ordered *Medicare patients see reverse side for important information.*

For insurance/Medicare provide ICD-9 diagnosis codes **for each test ordered.**

[X] **Urine Toxic Metals profile**

Collection Information:

→ Date final sample was collected: ___/___/___

→ Pt. Height (in.):_____ Pt. Weight (lb.):_____

→ Collection Period: ❑ Random – First morning void recommended
❑ Less than 24 hours – Number of hours:_____
❑ 24 hours – Volume (mL):_____ ***required***

→ If this sample is part of a provocative challenge; is it ❑ pre or [X] post?

→ Provoking agent: DMPS Dosage: 500 mg

Profile components:	CPT:	ICD-9 Diagnosis Codes (required):		
Aluminum	82108			
Arsenic	82175			
Heavy Metals*	83018			
* Includes: Antimony, Barium, Beryllium, Bismuth, Cesium, Gadolinium, Palladium, Platinum, Tellurium, Thallium, Thorium, Tin, Tungsten, Uranium				
Cadmium	82300			
Lead	83655			
Mercury	83825			
Nickel	83885			

AVAILABLE ADD-ON TESTS: (additional fees apply):

❑ Urine Iodine	84999			
❑ Urine Halides (I, Br & F)	MULTIPLE			
❑ Urine Essential Elements	MULTIPLE			
❑ Creatinine Clearance	82575			

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:_____

→ Iodine Loading Dose: _____

Client Reference:

4 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: ❑ Male ❑ Female

Mailing Address: _____

City: _____ State: _____ County (required for NY): _____ Zip: _____

Daytime Phone: (_____) _____ Evening Phone: (_____) _____ Patient Social Security #: _____ - _____ - _____

Responsible Party Name: _____ Responsible Party Social Security #: _____ - _____ - _____

Responsible Party Date of Birth: ____/____/____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Patient/Responsible Party Signature: I authorize and request payment of medical benefits be made directly to Doctor's Data, Inc. I authorize the release of any medical information necessary to process this claim. I agree to be personally and fully responsible for any portion of the claim not covered by my insurance carrier and agree to make such payment within 30 days. A service charge of 1.5% per month may be charged on balances over 30 days.

X *(Required)* _____ Date: _____ ***Medicare Patients read and sign ABN on back of form.***

THIS SPACE FOR LAB USE ONLY

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