Turtle Healing Band Clinic

Circulating Tumor Cell Requisition Form

Patient

Full Name:_____

Date of Birth:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____

Are you a member of the Turtle Healing Band? _____ Yes _____ No

Provider

Full Name:_____

Practice Name:_____

Office Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____

Are you licensed with First Nation Medical Board ("FNMB")? _____ Yes _____ No

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Payment

($795 FNMB Providers/$895 for Non-FNMB Providers/$995 for Patients)

Credit Card ☐ Debit Card ☐ Check ☐
Credit Card Type: VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX ☐
Credit/Debit Card Number:_____
Expiration:_____ Security Code:_____

I understand and agree that payment must accompany my blood sample, along with my lab requisition and my questionnaire, abnormal results should be repeated within 3 months, and my laboratory data may be used anonymously as part of a clinical study.

_____
Signature

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