MindX Blood Test™ Prescription Form

MindX Sciences

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Indianapolis, IN 46202

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Please complete and return by fax or email.

Prescriber Information:

Prescriber Name	
NPI	
Prescriber Email	Office Contact Name
Office/Hospital Name	Address
City	State Zip
Phone	Fax

Patient Information

Last Name	First Name, MI
Gender	DOB
Address	Apt.
City, State	Zip
Phone	Email

Please fill the following table:

		Yes, No, N/A, or write-in	Score (by MindX staff)
1	Relevant Clinical Diagnoses (write in)	Primary: Secondary:	
2	Receiving treatment for the disease?		
3	Did the patient score high recently on any clinical rating scale for the disease?		
4	Number of hospitalizations due to this disease (write in- if not known approximate or put N/A)		
5	Number of ER visits for this disease (write in- if not known approximate or put N/A)		
6	Patient is appropriately dressed and has good hygiene?		
7	Has a cognitive disease that can affect self-reporting? (schizophrenia, schizoaffective, dementias, ADHD, ASD)?		
8	Active addictions?		
9	Patient is on disability for the disease?		
10	Patient is in assisted living and/or has somebody manage their finances?		

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We will send the patient a MindX Blood Test kit, pre-labeled for

FedEx. Specimen Collection Location-if known (check one):

- ☐ Complimentary At Home Mobile Phlebotomist
- ☐ Your Office/Clinic
- ☐ Hospital Outpatient/ASC
- ☐ Community Lab Draw Location
- ☐ Hospital Inpatient

Please Choose Report	Product Catalog #	Test Description	**CPT Code**
☐	2001	MindX Blood Test™ Mood	0291U
☐	2002	MindX Blood Test™ Stress	0292U
☐	2003	MindX Blood Test™ Memory	0289U
☐	2004	MindX Blood Test™ Longevity	0294U
☐	2005	MindX Blood Test™ Suicidality	0293U
☐	2006	MindX Blood Test™ Pain	0290U
☐	2007	MindX Blood Test™ Anxiety	0437U
☐	2008	MindX Blood Test™ Psychosis	
☐	2009	MindX One™ Cross-Sectional (All Diseases)	
☐	2010	MindX One™ Longitudinal (All Diseases x 2)	

Prescriber Signature	Prescriber Name	Date