FRAT™ Folate Receptor Antibody Test

LABORATORY TEST FORM

DATE: _____

(PLEASE COMPLETE ENTIRE FORM. SAMPLES WITH INCOMPLETE FORMS WILL NOT BE TESTED)

A. Patient Information

Name (or ID) _____

_____

Gender _____

Date of Birth _____

Diagnosis _____

_____

B. Physician Information

Name _____

Address _____

_____

Email _____

Phone _____

FAX _____

C. Answer Is the patient taking product(s) that contain folinic acid or 5-MTHF? Circle **YES NO**

If yes, please indicate product _____

RESULTS

Results for FRAT, including Folate Receptor A Binding Antibodies and Folate Receptor A Blocking Antibodies, will be available in 10-14 business days.

Please indicate preferred method for receiving results (circle) **EMAIL FAX OTHER:** _____

Results of antibody assays will also be classified as either negative or positive.

Patient Consent

State and federal privacy laws protect the use and release of your health information. Under these laws, your personal information cannot be released to the testing laboratory unless you give your permission. Such information includes, but may not be limited to, your name, date of birth, and diagnosis. The laboratory team will use and protect your information as closely as possible. However, once your health information is released it may not be protected by the privacy laws and might be shared with others. If you have questions, ask a member of the research team. The information may be used by the testing laboratory, your physician, biopharmaceutical companies conducting research, and possibly regulatory agencies such as the FDA who review the quality and safety of the research and the data.

If you agree to the use and release of your Personal Health Information, please sign below. Upon request, you will be given a signed copy of this form.

After testing is completed, your remaining sample may be used for research purposes, such as the development of testing procedures or standards. **PLEASE CIRCLE YOUR ANSWER TO THE QUESTION BELOW.**

I agree to the use of my remaining sample for research-only purposes. Circle **YES NO**

_____

Subject's Name (print)

_____

Subject's Signature / Date

Disclaimer: The assays for binding and blocking antibodies to Folate Receptor A are currently being used for research purposes only. While they have been shown in several studies (references available upon request) to be associated with transport problems of folate into tissues (mostly brain and placenta), they are not intended to be used to diagnose any particular medical disorder. They have not been approved by any regulatory agency. More information is available upon request. Email: info@iliadneuro.com; Phone: 610-441-9050

FRAT™
Folate Receptor Antibody Test

PAYMENT INFORMATION
The cost of this test is $200. If paying by check, please make payable to **Iliad Neurosciences Inc.**
If paying by credit card, please fill out Credit Card Authorization Form below.

One Time Credit Card Payment Authorization Form

Sign and complete this form to authorize **Iliad Neurosciences Inc.** to make a one-time debit to your credit card listed below. By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I_____(full name) authorize

Iliad Neurosciences Inc. to charge my credit card account indicated

below for $_____ on or after_____(date).

This payment is for a FRA-Ab Lab Test.

Cardholder Name _____

Billing Address _____

Zip Code: _____

Email _____

Phone _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Account Number _____

Expiration Date _____

CVV2 (3-digit code back of Visa/MC, 4 digit on front of AMEX) **MUST INCLUDE** _____

_____

Signature / Date

* I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

BLOOD SAMPLE COLLECTION AND SHIPPING:

1. Acceptable samples are whole blood or serum.
2. Draw 2–4 ml of blood into a red-top tube or SST tube (serum).
3. If feasible: Remove red cells by centrifugation, transfer serum to clean tube and refrigerate (4°C) or freeze (-20°C) until time of shipping.
4. If whole blood must be sent, collect into red-top tube and ship the same day.
5. Ship stored serum with freezer packs. Ship whole blood at ambient temperature. If overnight shipment of serum is not possible or a lengthy transit time is anticipated, shipment with dry ice is recommended. Do not ship whole blood with dry ice.
6. Ship all tubes as PRIORITY OVERNIGHT using FedEx or UPS for delivery weekdays. No weekend or holiday deliveries will be accepted.
7. Minimum volume of serum acceptable is 1 ml (2 ml for whole blood).
8. Please make sure that each sample is properly and securely labeled, including name (or ID) and date.
9. Please ship to:
   Iliad Neurosciences, Inc.
   c/o VascularStrategies
   5110 Campus Drive, Suite 150
   Plymouth Meeting, PA 19462
   USA