



Micro Trace Minerals GmbH

30 Years of Clinical and Environmental Laboratory Services

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Sample Submission Sheet: IgG Antibody Testing

Sample ID: _____

Laboratory use only

Material needed: Serum, 2-3ml

Sampling Date: _____

Test requested: ___IgG100 ___IgG300

Patient name: _____ Date of Birth: _____

Patient mailing address: _____

Only needed if laboratory is asked to bill patient or send report to patient directly. Please print.

City _____ Country: _____

Phone: _____ FAX: _____

e-mail _____ needed if report should be send to patient e-mail. Please print.

Clinic or Praxis: _____

Address: _____ **Zip/town** _____

Country: _____ **Phone:** _____

___ Please e-mail report to _____

___ Please fax report to fax number: _____

Please Bill to: **Clinic or** **Patient** (see address above)

Payment via Visa or Mastercard : CC#: _____

exp. date _____ 3-digit security code

Card holder signature: _____ Date: _____

Bank Transfer: Raiffeisenbank Hersbruck
Blz: 760 614 82
Kto: 100 092 185
Swiftcode: Genodef1hsb
Iban: de70760614820 100092185