

PATIENT DETAILS *Mandatory Fields		Sample Collection		Date:	Time:
Full Name*:				HH:MM	
Date of Birth*:	Gender* ☐ M ☐ F	Sample Type			
Ethnicity:	Nationality:	Turnaround Time:		☐ Standard	☐ Fast Track
Phone/WhatsApp Number:		Fasting		☐ Yes	☐ No
Email:					
CLINICAL COMMENTS / MEDICATION:		Ref. Doctor:			
		Ref. Clinic:			

CHEX REQUEST CHECKLIST

- ☐ Age CheX

☐ Blood CheX

☐ Cortisol CheX^{5P}

☐ Cytokine CheX

☐ FoodSens CheX²⁴⁰

☐ Functional CheX ☐ M ☐ F

☐ Gut CheX

☐ Methylation CheX

☐ mTOR CheX

☐ Nutri CheX

☐ Oxi CheX

☐ Oxi CheX^{PLUS}

☐ Pathway CheX Comp

☐ Pathway CheX Allergy

☐ Pathway CheX Detoxification
- ☐ Pathway CheX Methylation

☐ Pathway CheX Neurotransmitters

☐ Risk CheX Comp

☐ Risk CheX^{5P}

☐ Risk CheX Cancer

☐ Risk CheX Cardio

☐ Risk CheX Digestive

☐ Risk CheX EndoMeta

☐ Risk CheX Immuno

☐ Risk CheX Neuro

☐ Sports CheX

☐ Toxi CheX

☐ Others

☐ Package

TO BE FILLED BY PERFORMING LAB ONLY	Received By:		Sample Quality / Other Comments:	Signature:	BARCODE NO:
	Date: DD/MM/YY	Time: HH:MM			