MTHFR Mutation Test Request Form

Patient Information

Name: John Doe

Date of Birth: 02/15/1980

Gender: Male

Contact Information: 123 Main Street, Anytown, USA

Reason for MTHFR Mutation Test

- [x] Family Planning
- [ ] Recurrent Pregnancy Loss
- [ ] Cardiovascular Risk Assessment
- [ ] Neurological or Psychiatric Disorders
- [ ] Personalized Healthcare Planning
- [ ] Other (Please specify): _____

Clinical History

Family History:
No known history of neural tube defects or cardiovascular disease.

Medical History:
No significant medical history. The patient and his partner plan to start a family and want to assess potential genetic risk factors.

Sample Collection

- [x] Blood Sample
- [ ] Saliva Sample

Additional Comments or Instructions
The patient has requested a blood sample for the MTHFR Mutation Test. Please guide any necessary dietary or supplementation changes based on the test results.

Patient Consent

I, the undersigned, understand the purpose and implications of the MTHFR Mutation Test and provide my consent for the test to be conducted.

Patient's Signature: John Doe **Date**: 10/25/2023