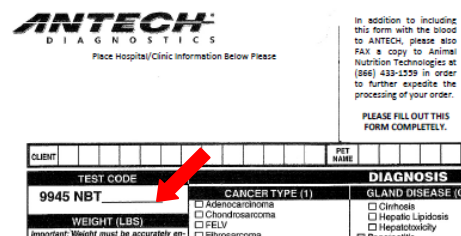


Congratulations on your decision to review the positive effects of integrating Nutritional Therapies on both your patients as well as your practice. If you should have any questions, please contact us at **888-533-5162**.

1. Patient Exam & Information:

- Complete the attached Questionnaire Test Form (Form 9945) with the relevant patient, historical medical and diagnosis information.
- Additional Forms can downloaded via our website at: http://animalnutritiontechnologies.com/NBT_Order_Form.pdf.
- Draw two vials of blood (red top serum separator and lavender top).



ANTECH
D I A G N O S T I C S
Place Hospital/Clinic Information Below Please

In addition to including this form with the blood to ANTECH, please also FAX a copy to Animal Nutrition Technologies at (866) 433-1559 in order to further expedite the processing of your order.
PLEASE FILL OUT THIS FORM COMPLETELY.

CLIENT	PET NAME
TEST CODE 9945 NBT	DIAGNOSIS
WEIGHT (LBS) <small>(reporting Weight must be accurately entered)</small>	CANCER TYPE (T) <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Chondrosarcoma <input type="checkbox"/> FELV <input type="checkbox"/> Fibrosarcoma GLAND DISEASE (G) <input type="checkbox"/> Chiroste <input type="checkbox"/> Hepatic Lipidosis <input type="checkbox"/> Hepatotoxicity <input type="checkbox"/> Plasmocytoma

2. Nutritional Blood Testing (NBT):

A. ANTECH Diagnostic Labs:

- Check the box on Form 9945 (as shown above) for the CBC, T4 and SuperChem (w/LDH) blood tests.
- Include 9945 with samples and coordinate with ANTECH for specimen pickup:
 - Eastern US Region: 800-872-1001
 - Western US Region: 800-745-4725
 - Canada: 800-341-3440
- FAX a copy of the Form 9945 to ANT at **866-433-1559**.

B. 3rd Party or In-House Labs:

- ANT is happy to accept blood results from outside labs.
- CBC, T4 and SuperChem blood tests should be completed.
- FAX both the blood results and the completed Form 9945 form with Veterinarian Contact Information to ANT at **866-433-1559**.

3. Nutraceuticals & Nutritional Therapies:

Within 72 hours of receiving the blood analysis and Questionnaire, ANT will deliver via email/fax a copy of the NBT Summary, which consists of two parts:

- Veterinarian EYES ONLY: with sensitive product pricing information.
- Consumer Section with full details of the analysis and Nutritional Therapy.

4. Complimentary Consultation:

- Telephone “VET-to-VET” consultation with Dr. Robert Goldstein, one of the original pioneers of integrative and complementary medicine with over 30 years experience developing the NBT program in a clinical environment, to:
 - To explain the results of the analysis and NBT Summary.
 - Adapt the nutritional therapy into your current treatment to maximize patient health & wellness benefits.
- Products ship within 48 hours and delivery takes between 3-5 days.

Please visit our website at www.animalnutritiontechnologies.com or call us at **888-533-5162** if you have any questions about our products or how we can better serve you.

Thank you.

Place Hospital/Clinic Information Below Please

In addition to including this form with the blood to ANTECH, please also FAX a copy to Animal Nutrition Technologies at (866) 433-1559 in order to further expedite the processing of your order.

THE FOLLOWING HISTORICAL, MEDICAL AND DIAGNOSTIC INFORMATION IS NECESSARY TO ACCURATELY ASSESS THE ANIMAL'S CURRENT CONDITION AND CREATE THE PROPER NUTRITIONAL AND SUPPLEMENTAL PROGRAM FOR THE NUTRITIONAL BLOOD TEST. QUESTIONS? CALL (888) 533-5162.

CHART # _____

SPECIES: CANINE FELINE **BREED:** _____

DOCTOR _____

SEX: M F Neutered Spayed

PLEASE FILL OUT THIS FORM COMPLETELY.

CLIENT _____ **PET NAME** _____ **DATE** ____/____/____

TEST CODE		DIAGNOSIS					
9945 NBT _____		CANCER TYPE (1)		GLAND DISEASE (CON'T)		MUSCULO-SKELETAL (CON'T)	
WEIGHT (LBS) <i>Important: Weight must be accurately entered for proper dosing of nutraceuticals.</i>		<input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Chondrosarcoma <input type="checkbox"/> FELV <input type="checkbox"/> Fibrosarcoma <input type="checkbox"/> Vaccine-Induced <input type="checkbox"/> Hemangiosarcoma <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma/Lymphosarcoma <input type="checkbox"/> Mast Cell <input type="checkbox"/> Melanoma <input type="checkbox"/> Osteosarcoma <input type="checkbox"/> Squamous Cell Carcinoma <input type="checkbox"/> Other _____		<input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatic Lipidosis <input type="checkbox"/> Hepatotoxicity <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Acute Pancreatitis <input type="checkbox"/> Pancreatic Insufficiency <input type="checkbox"/> Parathyroid <input type="checkbox"/> Nutritional Secondary <input type="checkbox"/> Primary <input type="checkbox"/> Ovaries/Uterus <input type="checkbox"/> Prostate/Testes <input type="checkbox"/> Other _____		<input type="checkbox"/> Hip Dysplasia <input type="checkbox"/> OCD <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Spinal Arthritis/Spondylosis <input type="checkbox"/> Other _____	
AGE (YEARS)		CANCER LOCATION (2)		HEAD & NECK DISEASE		REPRODUCTIVE DISORDERS	
SPECIMENS RECEIVED <i>FOR LAB USE ONLY</i> <input type="checkbox"/> SS <input type="checkbox"/> R <input type="checkbox"/> S <input type="checkbox"/> L		<input type="checkbox"/> Adrenal <input type="checkbox"/> Bladder/Transitional <input type="checkbox"/> Bone <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Brain/Nerves <input type="checkbox"/> Cutaneous <input type="checkbox"/> Heart <input type="checkbox"/> Intestines/Colon <input type="checkbox"/> Kidney <input type="checkbox"/> Liver/Gall Bladder <input type="checkbox"/> Lymph Node <input type="checkbox"/> Mammary <input type="checkbox"/> Oral/Throat/Nasal <input type="checkbox"/> Ovaries/Uterus <input type="checkbox"/> Pancreas <input type="checkbox"/> Prostate/Testes <input type="checkbox"/> Spleen <input type="checkbox"/> Stomach/Esophagus <input type="checkbox"/> Thoracic/Lung <input type="checkbox"/> Thyroid <input type="checkbox"/> Other _____		<input type="checkbox"/> Ear <input type="checkbox"/> Acute Otitis <input type="checkbox"/> Chronic (Narrow Canal) <input type="checkbox"/> Eye <input type="checkbox"/> Cataracts <input type="checkbox"/> Corneal Disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> Progressive Retinal Atrophy <input type="checkbox"/> Mouth <input type="checkbox"/> Eosinophilic Granuloma <input type="checkbox"/> Gingivitis/Periodontal <input type="checkbox"/> Stomatitis <input type="checkbox"/> Teeth <input type="checkbox"/> Loose <input type="checkbox"/> Plaque/Tartar <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other _____		<input type="checkbox"/> Dystocia <input type="checkbox"/> Eclampsia <input type="checkbox"/> Endometritis/Pyometra <input type="checkbox"/> Infertility <input type="checkbox"/> Mastitis <input type="checkbox"/> Ovaries/Uterus <input type="checkbox"/> Prostate/Testes <input type="checkbox"/> Pseudocyesis <input type="checkbox"/> Other _____	
CURRENT MEDICATIONS		CNS DISEASE		HEART/LUNG DISEASE		SKIN DISEASE	
<input type="checkbox"/> Anabolic Steroid <input type="checkbox"/> Antibiotic/Sulfonamide <input type="checkbox"/> Anticonvulsant <input type="checkbox"/> Antidepressant <input type="checkbox"/> Antidiarrheal <input type="checkbox"/> Antiemetic/Antispasmodic <input type="checkbox"/> Antifungal <input type="checkbox"/> Anthelmintic <input type="checkbox"/> Antihistamine <input type="checkbox"/> Antitussive <input type="checkbox"/> Bronchodilator <input type="checkbox"/> Cardiac <input type="checkbox"/> Chemotherapeutic <input type="checkbox"/> Corticosteroid <input type="checkbox"/> Digestive Enzyme <input type="checkbox"/> Diuretic <input type="checkbox"/> Fluid Therapy <input type="checkbox"/> Insulin <input type="checkbox"/> NSAID <input type="checkbox"/> Nutraceuticals <input type="checkbox"/> Ocular <input type="checkbox"/> Otic <input type="checkbox"/> Radiation <input type="checkbox"/> Thyroid <input type="checkbox"/> Tranquillizer <input type="checkbox"/> Other _____		<input type="checkbox"/> Convulsions <input type="checkbox"/> Degenerative Myelopathy <input type="checkbox"/> Encephalitis/Meningitis <input type="checkbox"/> GME <input type="checkbox"/> Herniated Disc <input type="checkbox"/> Paresis/Paralysis <input type="checkbox"/> Other _____		<input type="checkbox"/> Heart <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Conduction Disease <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heartworms <input type="checkbox"/> Valvular Disease <input type="checkbox"/> Lung/Respiratory <input type="checkbox"/> Allergy <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Collapsed Trachea <input type="checkbox"/> Lungworms <input type="checkbox"/> Pneumonia/Pneumonitis <input type="checkbox"/> Other _____		<input type="checkbox"/> Abscess/Pyoderma <input type="checkbox"/> Allergy/Dermatitis <input type="checkbox"/> Dust/Mold <input type="checkbox"/> Flea Bite <input type="checkbox"/> Food Allergy <input type="checkbox"/> Grass/Pollen <input type="checkbox"/> Pruritus <input type="checkbox"/> Trees <input type="checkbox"/> Alopecia/Dry Skin/Dandruff <input type="checkbox"/> Demodectic Mange <input type="checkbox"/> Eczema/Seborrhea <input type="checkbox"/> Fungal Infestation <input type="checkbox"/> Sarcoptic Mange <input type="checkbox"/> Other _____	
VACCINATIONS GIVEN WITHIN LAST YEAR		GASTROINTESTINAL DISEASE		INFECTIOUS DISEASE		URINARY TRACT DISEASE	
<input type="checkbox"/> Bordetella <input type="checkbox"/> Leptospirosis <input type="checkbox"/> Calicivirus <input type="checkbox"/> Lyme <input type="checkbox"/> K-9 Distemper <input type="checkbox"/> Panleukopenia <input type="checkbox"/> Chlamydia <input type="checkbox"/> Parainfluenza <input type="checkbox"/> Coronavirus <input type="checkbox"/> Parvovirus <input type="checkbox"/> FELV <input type="checkbox"/> Rabies <input type="checkbox"/> FIP <input type="checkbox"/> Other _____ <input type="checkbox"/> Hepatitis		<input type="checkbox"/> Bloat <input type="checkbox"/> Enteritis/Diarrhea <input type="checkbox"/> Flatulence <input type="checkbox"/> Food Allergy <input type="checkbox"/> Gastritis/Vomiting <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Internal Parasites <input type="checkbox"/> Malabsorption <input type="checkbox"/> Megacolon/Megaesophagus <input type="checkbox"/> Other _____		<input type="checkbox"/> Canine Distemper <input type="checkbox"/> Chlamydia <input type="checkbox"/> Feline URI <input type="checkbox"/> FIP/FIV <input type="checkbox"/> Herpes <input type="checkbox"/> Panleukopenia <input type="checkbox"/> Parvovirus <input type="checkbox"/> Tracheobronchitis <input type="checkbox"/> Other _____		<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Amyloidosis <input type="checkbox"/> Glomerular Nephritis <input type="checkbox"/> Interstitial Nephritis <input type="checkbox"/> Pyelonephritis <input type="checkbox"/> LUTD <input type="checkbox"/> Cystitis <input type="checkbox"/> Urolithiasis <input type="checkbox"/> Calcium Oxalate <input type="checkbox"/> Struvite <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Other _____	
DIAGNOSIS		GLAND DISEASE		MUSCULO-SKELETAL		MISCELLANEOUS	
AUTOIMMUNE DISEASE		<input type="checkbox"/> Addison's Disease <input type="checkbox"/> Cushing's Disease <input type="checkbox"/> Diabetes Insipidus <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Hypert thyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Liver Disease <input type="checkbox"/> Acute Hepatitis <input type="checkbox"/> Chronic-Active Hepatitis		<input type="checkbox"/> Arthritis <input type="checkbox"/> Elbow Dysplasia <input type="checkbox"/> Eosinophilic Panosteitis <input type="checkbox"/> Fracture		<input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Behavior Problems <input type="checkbox"/> Aggression <input type="checkbox"/> Depression/Apathy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Inappropriate Urination <input type="checkbox"/> Separation Anxiety <input type="checkbox"/> Cognitive Dysfunction <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Haemobartonella <input type="checkbox"/> Lethargy <input type="checkbox"/> Obesity <input type="checkbox"/> Tick-Borne Disease <input type="checkbox"/> Ehrlichiosis <input type="checkbox"/> Lyme Disease <input type="checkbox"/> Rocky Mt. Spotted Fever <input type="checkbox"/> Toxoplasmosis <input type="checkbox"/> Trauma/Injury <input type="checkbox"/> Wasting/Weakness <input type="checkbox"/> Other _____	