



Bitte dieses Feld
nicht bekleben.

Please leave this
box blank.

Prière de ne pas
étiqueter ce champ.

Praxisstempel/Practice stamp/Cachet du Cabinet

Belegnummer/Document number



0035 0228 02

Name/Name/Nom

Vorname/First name/Prénom

Geb./Dob/Né W/F/F M/M/M
Geschlecht/Sex/Sexe

Straße/Street/Rue

PLZ/ZIP Code/Code Postal Ort/City/Ville

Land/Country/Pays

Fon Fax

E-Mail

Lymphocyte transformation test (LTT)

for cellular allergy diagnosis

Please fill the relevant boxes

Price (€) per analysis / profile

metal profile I:

beryllium, cadmium, gold, indium, nickel, palladium,
inorganic mercury, lead, tin, zirconium

217,82

metal profile II:

aluminium, chromium, cobalt, ethyl-mercury, copper,
methyl-mercury, molybdenum, phenyl-mercury, platinum, silver

217,82

metal-profile I + II:

408,84

gold alloy

gold, beryllium, lead, cadmium, indium, copper, nickel,
Palladium, Platin, Silber

217,82

amalgam:

inorganic mercury, ethyl-, methyl-, phenyl-mercury
lead, copper, nickel, silver, tin, indium

217,82

implants:

aluminium, chromium, cobalt, molybdenum, nickel, palladium,
titanium, vanadium, zirkonium, indium

217,82

plastics:

methylmethacrylat (MMA), 2-hydroxyethyl-methacrylat (HEMA), triethylenglycoldimethacrylat (TEGDMA),
dibenzolperoxid (DBP), bisphenol-A-glycidmethacrylat (BisGMA), urethandimethacrylat (UDMA)

141,42

substance intolerance

individual request (per parameter)
Please supply 1 g of the respective substances

65,01

Postage:

15,00

total _____ €

Special tubes required – available upon request.

Testing of further type IV allergens (e.g. environmental noxins, food, plasticisers, flame retardants) via LTT is possible after consultation.

Supplementary information on conducting the test:

- at least 20ml CPDA blood per profile is required (40 ml for combi-profile)
- submission of sample preferably Monday through Wednesday, shipping at room temperature within approx. 60 hours..

For orders from outside of Germany advance payment by bank transfer is required before any desired testing can be carried out. Please transfer the total amount via SEPA-transfer to our account when ordering.

IBAN: DE79 3006 0601 0205 1568 40 BIC: DAAEEDDD Deutsche Apotheker- und Ärztebank eG

For payment and administrative purpose please provide the following information: Advance payment, {name, first name}, {date of order}

07/2017

I hereby commission the Med. Lab. Bremen to carry out the indicated tests and agree to cover any and all costs.

City / Country

Date

Signature

