

Stamp

Laboratory
Test Requisition Form (TRF)
to be sent to Eurofins Genoma Genoma Group
(* mandatory field)

Date: _____

PERSONAL DATA (Please fill in block letters)

Name*: _____ Surname*: _____ Date of Birth*: _____

ID Code*: _____ Place of Birth*: _____ Country.: _____

Sample Code (Doctor's duty): _____ Date of collection*: _____ Gender*: F ☐ M ☐

SAMPLE TYPE* (Check the corresponding box(es) and/or fill in)

- | | |
|---|---|
| <input type="checkbox"/> Blood (EDTA) | <input type="checkbox"/> Amniotic Fluid |
| <input type="checkbox"/> Blood (HEPARIN) | <input type="checkbox"/> CVS |
| <input type="checkbox"/> Swab (<i>Specify</i>) _____ | <input type="checkbox"/> Semen |
| <input type="checkbox"/> Other (<i>Specify</i>) _____ | |

ANALYSIS REQUIRED* (Check the corresponding box(es) and fill in)

Indication to the exam (**a physician's prescription is necessary for minors*): _____

Cytogenetic

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Traditional Karyotyping | <input type="checkbox"/> Alpha Feto Protein (AFP) | <input type="checkbox"/> Molecular Karyotyping (Array-CGH) | <input type="checkbox"/> QF-PCR (21,18,13,XY) |
|--|---|--|---|

Molecular Genetics

- | | |
|---|---|
| Cystic Fibrosis: <input type="checkbox"/> 39 mutation <input type="checkbox"/> 152 mutation
<input type="checkbox"/> Whole Gene | Beta Thalassemia: <input type="checkbox"/> Common <input type="checkbox"/> Whole Gene mutation |
| Deafness (GJB2/Cx26): <input type="checkbox"/> Common <input type="checkbox"/> Whole Gene mutation | <input type="checkbox"/> Deafness (GJB6/Cx30) Whole Gene |
| <input type="checkbox"/> Duchenne/Becker Muscular Dystrophy (DMD/DMB)
<input type="checkbox"/> Fragile-X Fraxa
<input type="checkbox"/> Spinal Muscular Atrophy (SMA) | <input type="checkbox"/> PrenatalScreen® Focus 31 Fetal Genetics Diseases
<input type="checkbox"/> PrenatalScreen® 1000 Fetal Genetics Diseases
<input type="checkbox"/> Other: _____ |

INVASIVE PRENATAL DIAGNOSIS

Cytogenetic

Male Fertility

- | | |
|---|--|
| <input type="checkbox"/> Traditional Karyotyping
<input type="checkbox"/> Molecular Karyotyping <i>High resolution</i>
<input type="checkbox"/> Couple Karyotype
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Y-Chromosome microdeletions
<input type="checkbox"/> FISH (Semen)
<input type="checkbox"/> DNA fragmentation test (TUNEL Test)
<input type="checkbox"/> Other: _____ |
|---|--|

POSTNATAL DIAGNOSIS

Molecular Genetics (*For Panels consult Vademecum*)

- | | |
|---|--|
| Cystic Fibrosis: <input type="checkbox"/> 139 mutation <input type="checkbox"/> 152 mutation <input type="checkbox"/> Whole Gene | |
| Beta Thalassemia: <input type="checkbox"/> Common mutation <input type="checkbox"/> Whole Gene | <input type="checkbox"/> Alfa Thalassemia (HBA1 e HBA2) MLPA |

Molecular Genetics <i>(For Panels consult Vademecum)</i>	
Deafness (GJB2/Cx26): <input type="checkbox"/> Common mutations <input type="checkbox"/> Whole Gene	<input type="checkbox"/> Deafness (GJB6/Cx30) - Whole Gene
<input type="checkbox"/> SMA – Carrier Test	<input type="checkbox"/> (DMD/DMB) Muscular Dystrophy MLPA Carrier Test <input type="checkbox"/> Fragile-X Fraxa
21-Hydroxylase deficiency (CYP21A2): <input type="checkbox"/> Common mutation <input type="checkbox"/> Whole Gene RDB + MLPA	
Hemochromatosis: <input type="checkbox"/> 3 mutation <input type="checkbox"/> 12 mutation <input type="checkbox"/> 18 mutation	<input type="checkbox"/> Hemophilia A - Factor VIII - Whole Gene
Fattore V: <input type="checkbox"/> Leiden <input type="checkbox"/> Cambridge <input type="checkbox"/> H1299R - R2 <input type="checkbox"/> Y1702C	<input type="checkbox"/> Factor II-Prothrombin <input type="checkbox"/> Beta Fibrinogen
MTHFR: <input type="checkbox"/> C677T <input type="checkbox"/> A1298C	<input type="checkbox"/> PAI-1 <input type="checkbox"/> HPA <input type="checkbox"/> ApoE <input type="checkbox"/> ApoB <input type="checkbox"/> ACE <input type="checkbox"/> AGT <input type="checkbox"/> Factor XIII
Thrombophilia: <input type="checkbox"/> 4 mutation <input type="checkbox"/> 5 mutation <input type="checkbox"/> Recurrent Pregnancy Loss <input type="checkbox"/> 15 mutation	
HLA: <input type="checkbox"/> Locus <i>(Specify)</i> _____	<input type="checkbox"/> I Class <input type="checkbox"/> II Class <input type="checkbox"/> HLA-G
<input type="checkbox"/> Jak2-single mutation (V617F)	<input type="checkbox"/> Genetic Screening for Myeloproliferative Diseases (MPL, CALR e JAK2)
CardioScreen®: <input type="checkbox"/> Cardiomyopathies Panel <input type="checkbox"/> Sudden Cardiac Arrest Panel	
GExome: <input type="checkbox"/> Clinical <input type="checkbox"/> Clinical Trio <input type="checkbox"/> Proband (WES) <input type="checkbox"/> Trio (WES)	
<u>Upon request:</u>	
Custom Panel <i>(Specify Gene/s)</i> : _____	
<u>Other (refer to Vademecum):</u>	
Code: _____ Analysis/Panel Type: _____	

INFORMED CONSENT* (Check the corresponding box)

Informed Consent: ☐ attached
☐ stored by Physician/Laboratory

N.B.: *The Physician/Laboratory, in case of a minor, has already collected the Informed Consent and retained the identity documents of the minor and all legal guardians.*

INVOICING AND REPORTING * (Check the corresponding box(es) and fill in)

Mailing preferences:

PHYSICIAN / LABORATORY *(According to Eurofins Genoma information sheet)*

PATIENT - Online *(Fill in the data below)*

Invoice

Report

☐
☐
☐
☐

Patient billing information: E-mail address: _____

Address: _____ n. _____ Zip Code: _____ City: _____ Country: _____

Patient reporting information:

E-mail address: _____ Phone number: _____

Indications for first access are available at <https://www.laboratoriogenoma.eu/en/>.

I the undersigned _____ authorize in accordance with Reg. EU 2016-679 to the sending of the report in the manner indicated above.

SIGNATURE* _____ Parent and/or guardian's signature: _____

To be fill out by employees of Eurofins Genoma *(Indicate the number and type of samples received):*

<input type="checkbox"/> Blood (EDTA) n° _____	<input type="checkbox"/> Amniotic Fluid	Date and time: _____ Signature (Abbreviation): _____
<input type="checkbox"/> Blood (HEPARIN) n° _____	<input type="checkbox"/> CVS	
<input type="checkbox"/> Swab <i>(Specify)</i> _____ n° _____	<input type="checkbox"/> Semen	
<input type="checkbox"/> Other <i>(Specify)</i> _____ n° _____		