

Stamp



Test Requisition Form

to be sent to Eurofins Genoma Group

Prot.: _____

Date: _____

(*Mandatory fields)

PATIENT 1 INFORMATION* (Fill in in block letters)

Name*: _____ Surname*: _____ Date of birth*: _____

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

External Code (Reserved to the Lab): _____ Sample Collection Date*: _____ Gender*: F ☐ M ☐

Type of sample: ☐ Blood ☐ Buccal Swab Other: _____

Indication to the exam:

- ☐ Donor screening
- ☐ Preconception screening
- ☐ Prenatal screening

- ☐ Known carrier (attach report)
- ☐ Positive family history (attach report)

Other _____

Gestational age: week _____ + days _____

PATIENT 2 INFORMATION (Fill in if two samples are submitted)

Name*: _____ Surname*: _____ Date of birth*: _____

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

External Code (Reserved to the Lab): _____ Sample Collection Date*: _____ Gender*: F ☐ M ☐

Type of sample: ☐ Blood ☐ Buccal Swab Other: _____

Indication to the exam:

- ☐ Donor screening
- ☐ Preconception screening
- ☐ Prenatal screening

- ☐ Known carrier (attach report)
- ☐ Positive family history (attach report)

Other _____

Gestational age: week _____ + days _____

If your partner has previously taken a carrier screening test, please fill in the fields below

Name and Surname: _____ Sample Code: _____

☐ Report attached (thick if yes)

ANALYSIS REQUIRED AND ADDITIONAL SERVICES* (Check the corresponding box/boxes and fill in)

- ☐ GeneScreen Focus
- ☐ GeneScreen Protect
- ☐ Genescreen Easy-Donor
- ☐ Genescreen Complete

- ☐ Matching
- ☐ Extension (specify the gene/s or the panel)

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INFORMED CONSENT* (Check the corresponding box)

- ☐ attached to this form
☐ stored by the applicant (Doctor/Clinic/Laboratory)

N.B.: Please remember to fill in an informed consent form for each patient.

INVOICING AND REPORTING PREFERENCES* (Check the corresponding box/boxes and fill in)

INVOICE

REPORT

DOCTOR/CLINIC/LABORATORY (According to Eurofins Genoma information sheet)

☐☐

PATIENT - Online (fill out the following fields)

☐☐

PATIENT 1 INVOICE INFORMATION: E-mail address: _____

Address: _____

PATIENT 2 INVOICE INFORMATION: E-mail address: _____

Address: _____

PATIENT/S REPORTING INFORMATION: First-time access instructions are available at: <https://www.laboratorigenoma.eu/>.

PATIENT 1: I, the undersigned, authorize Eurofins Genoma laboratory to provide the result of the analysis in the manner indicated above.

PATIENT 2: I, the undersigned, authorize Eurofins Genoma laboratory to provide the result of the analysis in the manner indicated above.

E-mail*: _____ Phone number: _____

E-mail: _____ Phone number: _____

Patient 1 Signature*: _____

Patient 2 Signature: _____

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

- ☐ Blood (EDTA) n° _____
☐ Blood (HEPARIN) n° _____
☐ Swab (*Specify*) _____ n° _____
☐ Other (*Specify*) _____ n° _____

Date and time:

Signature (Abbreviation):