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Test Requisition Form

to be sent to Eurofins Genoma Group

Prot.: Date:
Pate of birth*:
Gender*: F M M
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<u>ed)</u>
Date of birth*:
Gender*: F M M
port) stach report)

(*Mandatory fields)		Date:
	PATIENT 1 INFO	RMATION* (Fill in in block letters)
Name*:	Surname	*: Date of birth*:
ID*:	Place of Birth*:	Country:
External Code (Reserved to the La	ab):	Sample Collection Date*: Gender*: F \(\Boxed{\omega} \) M \(\Boxed{\omega}
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	
PAT	TENT 2 INFORMATI	ON <u>(Fill in if two samples are submitted)</u>
Name*:	Surnam	e*: Date of birth*:
ID*:	_ Place of Birth*:	Country:
External Code (Reserved to the I	_ab):	Sample Collection Date*: Gender*: F M
Type of sample:	☐ 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	s 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	Matching
GeneScreen Protect	Extension (specify the gene/s or the panel)
Genescreen Easy-Donor	
Genescreen Complete	

Mod. PR 11 W1 ENG Rev. 02 dated 05/04/2024



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INFORMED CONSENT*	(Check the corresponding bo	x)	
□ 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 PREFERENCE	ES* (Check the correspondir	ng box/boxes and fill in)	
DOCTOR/CLINIC/LABORATORY (According to Eurofins Genoma information PATIENT - Online (fill out the following fields)	INVOICE on sheet)	REPORT	
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 av	railable at: <u>https://www.laborato</u> i	riogenoma.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 same	ples received):		
□ Blood (EDTA) n°		Date and time:	
☐ Blood (HEPARIN) n°			
Swab (Specify) n° n°		Signature (Abbreviation):	
Other (Specify)n°			

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