



Genoma

Affix stamp here



Test Requisition Form

Date: _____

N. prot. _____

SAMPLE DETAILS (fill in block letters)

First and Last Name: _____ Date of Birth*: _____

Sample Code (for Physician/Laboratory use): _____ Date of collection: _____

Biological sample: ☐ Buccal swab ☐ Blood (EDTA)

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

REPORTING PREFERENCES (Check the corresponding box/boxes)

☐ PHYSICIAN/LABORATORY☐ PATIENT (online)In order to activate the **on-line reporting**, you need to provide us an E-mail address:

_____ and a phone number: _____

Indications for first access are available at <https://www.laboratorio-genoma.eu/>

I the undersigned _____

hereby authorize in accordance with Regulation EU 679/2016 to the sending of the report in the manner indicated above.

SIGNATURE _____

INVOICING (Check the corresponding box/boxes)

☐ PHYSICIAN/LABORATORY (according to EUROFINS GENOMA information sheet)☐ PATIENT (fill in the data below)

Patient's data

Name and Surname: _____

Date of birth: _____ Place of birth: _____

Address: _____ City: _____

ANALYSIS DETAILS

- ☒ Predisposition to OBESITY
- ☒ Predisposition to gestational DIABETES
- ☒ COELIAC DISEASE
- ☒ Predisposition to POLYCYSTIC OVARY SYNDROME
- ☒ Predisposition to ENDOMETRIOSIS
- ☒ Predisposition to the risk of MISCARRIAGE
- ☒ Response to OVARIAN STIMULATION



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