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.laboratoriogenoma.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 OVARIC STIMULATION