

Microbiology

Test Requisition Form to be sent to Eurofins Genoma Group Date: _____ (*Mandatory) **PERSONAL DETAILS** (Please, fill in block letters) Name*: ______ Date of Birth*: ______ ID Code*: _____ Place of Birth*: _____ Country.: ____ Sample Code (**Doctor's duty**): _____ Collection date*: ____ Gender*: F \square M \square **SAMPLE INFORMATION** * (Check the corresponding box/boxes and fill in) Sample type: Site of sampling: □ Thin-prep ☐ Other (*Specify*): ■ Buccal □ Urethral ☐ Other (*Specify*): _____ ☐ Dry Swab ■ Vaginal ☐ Gel Swab □ Cervical ■ Semen ■ Rectal **ANALYSIS REQUIRED*** (Check the corresponding box/boxes and fill in) Indication to the exam (*a physician's prescription is mandatory for minors): ☐ CMV Quantitative ☐ Candida albicans □ CMV ☐ Trichomonas vaginalis ☐ EBV ☐ EBV Quantitative ☐ Gardnerella vaginalis ☐ HCV ☐ HCV Quantitative ☐ Chlamydia trachomatis ☐ HBV ☐ HBV Quantitative ☐ HDV ☐ Mycoplasma genitalium ☐ HDV Quantitative ■ Mycoplasma hominis ☐ HIV-RNA ☐ HIV-RNA Quantitative ☐ Neisseria gonorrhoeae ☐ HIV-DNA ☐ HHV6 ☐ Ureaplasma urealyticum ☐ HSV 1/2 ☐ Rubeovirus ☐ Ureaplasma parvum ☐ Toxoplasma ☐ Other (Specify): □ VZV ☐ Staphylococcus saprophyticus ☐ Streptococcus agalactiae -Beta Emolitico ☐ Helicobacter pylori molecular (Dry swab) ☐ Mycoplasma pneumoniae ☐ STI Panel ☐ Mycobacterium tubercolosis (Chlamydia, Gardnerella, M. Genitalium, M. Hominis, Neisseria, Trichomonas, U. Urealitycum e U. Parvum) ☐ Common Germ Antibiogram ☐ Common Germ Swab SERVICE ☐ Other (*Specify*): ☐ Sterptococcus agalactiae - Beta emolitico cultural (Gel swab)

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Stamp			

to be sent to Eurofins Genoma

(*Mandatory)

HISTORY NOTES and/or OBJECTIVE EX	XAMINATION * (Plea	ase, fill in)				
Clinical suspicion:						
Clinical information (past infections, past or current therapies, ϵ	etc.):					
Specialist's Si	gnature*					
Specialist's Signature*:						
INVOICING AND REPORTING * (Check th	e corresponding box/bo	xes and fill in)				
Mailing preferences:	Invoice Re	port				
PHYSICIAN / LABORATORY (According to Eurofins Genoma information sheet)		¬				
PATIENT - Online (Fill in the fields below)						
Patient billing information: E-mail address:						
Address: n Zip Cod	de: City:	Country:				
Patient reporting information:						
E-mail address: Phone number:						
Indications for first access are available at https://www.laboratoriogenoma.eu/en/ .						
the undersigned authorize in ac	cordance with Reg. EU 2016-	679 the sending of the report in the manne				
indicated above.						
SIGNATURE* Parent and/or guardian's signature:						
To be filled out by employees of Eurofins Genoma (Indicate the number and typ	e of samples received):					
☐ Blood (EDTA) n°	☐ Amniotic Fluid	Date and time:				
□ Serum n°	□ CVS					
□ Dry Swab n°	□ Semen	Signature (Abbreviation):				
Gel Swab n°						
□ Other <u>(Specify)</u> n°						

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