eurofins | Genoma

Stamp

Microbiology
Test Requisition Form
to be sent to Eurofins Genoma Group

*(*Mandatory)*

Date: _____

PERSONAL DETAILS *(Please, fill in block letters)*

Name*: _____ Surname*: _____ Date of Birth*: _____

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

Sample Code (**Doctor's duty**): _____ Collection date*: _____ Gender*: F ☐ M ☐

SAMPLE INFORMATION * *(Check the corresponding box/boxes and fill in)*

Sample type:

☐ Thin-prep	☐ Other (*Specify*):
☐ Dry Swab	_____
☐ Gel Swab	_____
☐ Semen	_____

Site of sampling:

☐ Buccal	☐ Urethral
☐ Vaginal	☐ Other (*Specify*): _____
☐ Cervical	_____
☐ Rectal	_____

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

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

_____

MOLECULAR

☐ *Candida albicans*	☐ CMV	☐ CMV Quantitative
☐ *Trichomonas vaginalis*	☐ EBV	☐ EBV Quantitative
☐ *Gardnerella vaginalis*	☐ HCV	☐ HCV Quantitative
☐ *Chlamydia trachomatis*	☐ HBV	☐ HBV Quantitative
☐ *Mycoplasma genitalium*	☐ HDV	☐ 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*):
☐ *Staphylococcus saprophyticus*	☐ VZV	_____
☐ *Streptococcus agalactiae -Beta Emolitico molecular* (Dry swab)	☐ *Helicobacter pylori*	_____
	☐ *Mycoplasma pneumoniae*	
☐ STI Panel (*Chlamydia, Gardnerella, M. Genitalium, M. Hominis, Neisseria, Trichomonas, U. Urealitycum e U. Parvum*)	☐ *Mycobacterium tubercolosis*	_____

SERVICE

☐ Common Germ Swab	☐ Common Germ Antibiogram
☐ *Sterptococcus agalactiae - Beta emolitico* cultural (Gel swab)	☐ Other (*Specify*): _____
	_____

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HISTORY NOTES and/or OBJECTIVE EXAMINATION * *(Please, fill in)*

Clinical suspicion: _____

Clinical information (past infections, past or current therapies, etc.):

_____

_____

Specialist's Signature*: _____

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

Mailing preferences:	*Invoice*	*Report*
PHYSICIAN / LABORATORY *(According to Eurofins Genoma information sheet)*	☐	☐
PATIENT - Online *(Fill in the fields below)*	☐	☐

Patient billing information: E-mail address*:* _____

Address: _____ n. _____ Zip Code: _____ City: _____Country: _____

Patient reporting information:

E-mail address: _____ Phone number: _____

Indications for first access are available at https://www.laboratoriogenoma.eu/en/.

I the undersigned _____ authorize in accordance with Reg. EU 2016-679 the sending of the report in the manner indicated above.

SIGNATURE* _____ Parent and/or guardian's signature: _____ _____

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

☐ Blood (EDTA) n° ____ ☐ Serum n° ____ ☐ Dry Swab n° ____ ☐ Gel Swab n° ____ ☐ Other *(Specify)* _____ n° ____	☐ Amniotic Fluid ☐ CVS ☐ Semen	Date and time: _____ Signature (Abbreviation): _____