eurofins | Genoma

Stamp

Uro-genital cytology
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:	Site of sampling:	
☐ Slide	☐ Endocervical	☐ Endometrius
☐ Thin-prep	☐ Exocervical	☐ Anus
☐ Dry Swab	☐ Vaginal dome	☐ Other: _____

Gynecological objectivity_____

_____

☐ Atypical blood loss

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

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

_____

HPV

- ☐ HPV High-Risk - HR *(14 Virotypes)*
- ☐ HPV mRNA (Dry Swab or Thin-prep)
- ☐ HPV High & Low Risk *(28 Virotypes)*
- ☐ HPV p16 immunohistochemistry on cytology (Thin-prep)

CYTOLOGY AND HPV

- ☐ PAP-TEST (Slide)
- ☐ Liquid Phase PAP-test (Thin-prep)
- ☐ FULL-PAP test on cytology: (PAP-test Thin-prep + HPV High Risk+ p16 immunohistochemistry)
- ☐ DUOPAP High Risk- HR: (Thin-prep PAP-test + HPV High Risk 14 Virotypes)
- ☐ DUOPAP High & Low Risk: (Thin-prep PAP-test + HPV High & Low Risk 28 Virotypes)

Other: If further Microbiology tests are required, in addition to HPV, refer to the dedicated TRF (Mod. PR 11 G1 ENG).

N.B. For these additional investigations an additional swab is required.

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HISTORY NOTES and/or OBJECTIVE EXAMINATION * *(Check the corresponding box/boxes and fill in)*

Date LMP: ____/_____/_____	☐ Menopause	☐ Pregnancy (Week:_____)	☐ Breastfeeding
Contraceptive therapies:	☐ **Pill:** ☐ In progress ☐ Previously	☐ **IUD:** ☐ In progress ☐ Previously	
☐ **Other therapies** (*Specify*): _____			

Previous cytological/histological examinations:

Date of execution:
_____
_____

☐ DTC ☐ Laser therapy	☐ Coning ☐ Leep	☐ Total hysterectomy ☐ Sub-total hysterectomy

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):*

☐ Slide n° ____ ☐ Thin-prep n° ____ ☐ Dry Swab n° ____ ☐ Other *(Specify)* _____ n° ____	Date and time: _____ Signature (Abbreviation): _____