

Affix stamp here



Genoma

Test Requisition Form

Date: _____

N. prot. _____

SAMPLE DETAILS (fill in block letters)

Name and Surname: _____ 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 (select the analysis required)

INTOLERANCE Line

 Coeliac disease predisposition Lactose intolerance Alcohol sensitivity Metabolism of caffeine Nickel sensitivity Histamine sensitivity Intolerance Complete (includes all panels of the Intolerance line)

HEALTH Line

 Homocysteine metabolism Cardiovascular health Inflammatory response Detox Bone health Metabolic Health Health Complete (includes all panels of the Health line)

SPORT & WELLNESS Line

 Metabolic Health Sport Sport & Wellness Complete (includes all panels of the Sport & Wellness line) Nutrinext TOTAL (includes all panels of the NUTRINEXT lines)

Please note that the genetic predisposition test for coeliac disease does not involve allelic typing of the loci investigated, but is aimed at finding the alleles of susceptibility to coeliac disease (DQA1*03, DQA1*05, DQB1*02, DQB1*03:02, DR3, DR4, DR5, DR7, DR9)

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