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Stamp

Laboratory Test Requisition Form (TRF)

to be sent to Eurofins Genoma Genoma Group)

(* mandatory field)

Date: _____

PERSONAL DATA (*Please fill in block letters*)

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

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

Sample Code (Doctor's duty): _____ Date of collection*: _____ Gender*: F ☐ M ☐

SAMPLE TYPE* (Check the corresponding box(es) and/or fill in)

- ☐ Blood (EDTA)
- ☐ Blood (HEPARIN)
- ☐ Swab *(Specify)* _____
- ☐ Other *(Specify)* _____
- ☐ Amniotic Fluid
- ☐ CVS
- ☐ Semen

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

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

_____

INVASIVE PRENATAL DIAGNOSIS

Cytogenetic

- ☐ Traditional Karyotyping
- ☐ Alpha Feto Protein (AFP)
- ☐ Molecular Karyotyping (Array-CGH)
- ☐ QF-PCR (21,18,13,XY)

Molecular Genetics

Cystic Fibrosis: ☐ 34 mutation ☐ 139 mutation ☐ 152 mutation ☐ Whole Gene	Beta Thalassemi ☐ Common mutation ☐ Whole Gene	
Deafness (GJB2/Cx26): ☐ Common mutation ☐ Whole Gene	☐ Deafness (GJB6/Cx30) Whole Gene	
☐ Duchenne/Becker Muscular Dystrophy (DMD/DMB) ☐ Fragile-X Fraxa ☐ Spinal Muscular Atrophy (SMA)	☐ PrenatalScreen® Focus 31 Fetal Genetics Diseases ☐ PrenatalScreen® 1000 Fetal Genetics Diseases ☐ Other: _____	

POSTNATAL DIAGNOSIS

Cytogenetic

- ☐ Traditional Karyotyping
- ☐ Molecular Karyotyping *High resolution*
- ☐ Couple Karyotype
- ☐ Other: _____

Male Fertility

- ☐ Y-Chromosome microdeletions
- ☐ FISH (Semen)
- ☐ DNA fragmentation test (TUNEL Test)
- ☐ Other: _____

Molecular Genetics *(For Panels consult Vademecum)*

Cystic Fibrosis:	☐ 34 mutation	☐ 139 mutation	☐ 152 mutation	☐ Whole Gene
Beta Thalassemia:	☐ Common mutation	☐ Whole Gene	☐ Alfa Thalassemia (HBA1 e HBA2) MLPA	

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POSTNATAL DIAGNOSIS

Molecular Genetics *(For Panels consult Vademecum)*

Deafness (GJB2/Cx26): ☐ Common mutations ☐ Whole Gene					☐ Deafness (GJB6/Cx30) - Whole Gene			
☐ SMA – Carrier Test			☐ (DMD/DMB) Muscular Dystrophy MLPA Carrier Test					☐ Fragile-X Fraxa
21-Hydroxylase deficiency (CYP21A2): ☐ Common mutation					☐ Whole Gene RDB + MLPA			
Hemochromatosis: ☐ 3 mutation	☐ 12 mutation	☐ 18 mutation			☐ Hemophilia A - Factor VIII - Whole Gene			
Fattore V: ☐ Leiden	☐ Cambridge	☐ H1299R - R2	☐ Y1702C		☐ Factor II-Prothrombin		☐ Beta Fibrinogen	
MTHFR: ☐ C677T	☐ A1298C	☐ PAI-1	☐ HPA	☐ ApoE	☐ ApoB	☐ ACE	☐ AGT	☐ Factor XIII
Thrombophilia: ☐ 4 mutation	☐ 5 mutation	☐ Recurrent Pregnancy Loss			☐ 15 mutation			
HLA: ☐ Locus *(Specify)* _____			☐ I Class	☐ II Class	☐ HLA-G			
☐ Jak2-single mutation (V617F)			☐ Genetic Screening for Myeloproliferative Diseases (MPL, CALR e JAK2)					
CardioScreen®: ☐ Cardiomyopathies Panel			☐ Sudden Cardiac Arrest Panel					
GExome: ☐ Clinical	☐ Clinical Trio	☐ Proband (WES)	☐ Trio (WES)					

Upon request:

Custom Panel *(Specify Gene/s):* _____

Other (refer to Vademecum):

Code: _____ **Analisys/Panel Type:** _____

INFORMED CONSENT* *(Check the corresponding box)*

Informed Consent: ☐ attached
☐ stored by Physician/Laboratory

N.B.: *The Physician/Laboratory, **in case of a minor**, has already collected the Informed Consent and retained the identity documents of the minor and all legal guardians.*

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

Mailing preferences:	*Invoice*	*Report*
PHYSICIAN / LABORATORY *(According to Eurofins Genoma information sheet)*	☐	☐
PATIENT - Online *(Fill in the data 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 to the sending of the report in the manner indicated above.

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

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

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