eurofins | Genoma

Stamp

Bi-Test and Pre-eclampsia Requisition Form

to be sent to Eurofins Genoma Group

*(*Mandatory field)* Date*: _______________

PERSONAL DATA *(Please fill in block letters and check the corresponding box(es))*

Name*:_______________________________ Surname*: ______________________ Date of Birth*: ____________

Tax Code*: ____________________________ Place of Birth*: _________________________ Country: __________

Sample Type: ✓ **Serum**

Ethnic group *:

☐ European or North African ☐ East Asian ☐ Unknown ethnicity or other
☐ African/Caribbean ☐ South Asia
☐ Mixed ethnicity ☐ Southeast Asia

Weight (kg)*: __________ Heigt (cm) *: __________ Smoke*: ☐ Yes ☐ No

ULTRASOUND DATA* *(Check the corresponding box(es) and fill in)*

Ultrasound date: __/__/____ Date LMP: ______________ EG: _______________ Donor Age: __________

CRL (between 45 and 85 mm): _________ mm NT: __________ mm DBP: ______________ mm

☐ Single pregnancy	☐ Twin pregnancy ☐ Vanishing twin	☐ Bicorial/biamniotic ☐ Monochorial/biamniotic ☐ Monochorial/monoamniotic

Soft markers:

☐ Nasal bone ☐ Cardiac echogenic foci ☐ Choroid plexus cysts	☐ Short femur ☐ Hyperechoic intestine ☐ Umbilical artery	☐ Pielectasia ☐ Humerus short ☐ Other: ________________

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

☐ *Bi- Test* ☐ ***Bi-Test Processing*** ☐ **Pre-eclampsia**

Date__________ Physician's Signature: ____

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*(*Mandatory field)*

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

Indicate mailing preferences:	*Invoice*	*Report*
PHYSICIAN/ LABORATORY *(According ro Eurofins Genoma information sheet)*	☐	☐
PATIENT - Online *(Fill in 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: ____________________

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

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

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