

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

☐ Thin-prep

☐ Dry Swab

☐ Endocervical

☐ Exocervical

☐ Vaginal dome

☐ Endometrius

☐ Anus

☐ 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 High & Low Risk (28 Virotypes)

☐ HPV mRNA

(Dry Swab or 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.laboratorigenoma.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):