

dated 16/10/2026

MD/HOSPITAL/LAB STAMP



N. Prot.: _____

Date: _____

Test Requisition Form *(*Mandatory field)*

SAMPLE DETAILS

Name and Surname*: _____ Birth Date*: _____

Sample Code (Doctor's duty): _____ Collection date*: _____ Gender*: F ☐ M ☐Sample: ☒ EDTA Peripheral Blood

Test requisition indications*:

- ☐ Couples with recurrent pregnancy loss history and/or repeated implantation failures
- ☐ Couples with history or risk of pre-eclampsia
- ☐ Selection of sperm donors in heterologous male assisted fertilization
- ☐ Selection of egg donors in heterologous female assisted fertilisation
- ☐ Selection of donors for embryo donation/double donation of gametes
- ☐ Other: _____

ANALYSIS DETAILS* (Please check the box)

- ☐ Affinitymap HLA-C
- ☐ Affinitymap KIR
- ☐ Affinitymap KIR+HLA-C

REPORTING PREFERENCES

☒ MD/ HOSPITAL / LAB

INVOICING PREFERENCES (Select the box accordingly)

☐ MD/ HOSPITAL / LAB *(according to EUROFINS GENOMA information sheet)*☐ PATIENT *(Please fill underneath)*

NAME SURNAME: _____ TAX ID: _____

City of birth: _____ District of Birth: _____

Address: _____ n. _____ ZIP CODE: _____

Town: _____ Country: _____