BIOANALYSIS
CLINICAL LAB

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Genetic Testing Referral Letter

Patient details

Name:_____ Surname: _____

D.O.B.: _____/_____/_____ I.D. No.: _____

Nationality: _____ Gender: ☐Male ☐Female

CING No.: _____ Hospital Card No.: _____

Patient Status: ☐GP ☐ PP

Address: _____

City: _____ Code: _____ Country: _____

Phone: Home: _____ Work: _____

Fax: _____

e-mail: _____

Referring clinician's / scientist's details

Name:_____ Surname: _____

Hospital / Clinic: _____

Address: _____

City: _____ Code: _____ Country: _____

Phone: _____ Fax: _____

e-mail: _____

Reason for Referral:_____

_____

Signature: _____ Date: ___/____ /_____

Sample details *(Please tick ☑ accordingly)*

Date and Time of Sample Collection:_____

Sample: ☐Blood (3-4ml) ☐CVS

Other (please specify):_____

☐First Investigation ☐Repetition

For Genetic Testing 3-4ml whole blood is required in EDTA. red.

Sample Receipt (*For Laboratory Internal Use)*

Received by: _____ Signature: _____

Sample Receipt Date: ____ / ____ / _____

Amount: _____ Comments: _____

Test Required (Code No.) *(Please tick ☑ accordingly)*

Cystic Fibrosis (CF):
☐ CF full mutation analysis
☐ CF analysis for known mutation
☐ CF prenatal diagnosis

Familial Mediterranean Fever (FMF):
☐ FMF full mutation analysis
☐ FMF analysis for known mutation

Haemochromatosis:
☐ Haemochromatosis analysis for individual mutations

Factor V Leiden:
☐ Genetic analysis for Factor V Leiden
☐ Factor V Leiden analysis for known mutation

Haemophilia:
☐ Haemophilia analysis

Homocysteinaemia:
☐ Homocysteinaemia analysis for MTHFR C677T and A1298C mutations

Prothrombin:
☐ Prothrombin analysis for G20210A mutation

☐ **Other DNA analysis upon request**

☐ **Other DNA extraction/storage**

Patient Inform Consent *(Please read and sign)*

I authorize the Clinical Laboratory Bioanalysis to use my (or my child's/my foetus) sample (whole blood, serum or CVS) for genetic testing or storage.

I have the right to refuse the above and request disposal of my sample. Samples are stored for future reference or use only.

☐ I can withdraw my consent at any time by contacting the laboratory at +35725 72 62 52

Patient/Guardiant Signature: _____