

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)*: _____ Height (cm) *: _____

Smoke*: ☐ Yes ☐ No Number of cigarettes per day: _____

Diabetes*: ☐ Yes ☐ No (Type: _____)

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

US date: _____ Date LMP: _____ EG*: _____ Method of conception*: _____

CRL (between 45 and 84 mm): _____ mm NT: _____ mm DBP: _____ mm

Donor Age: _____ Date of donation: ____/____/____ Date of conception: ____/____/____

Number of pregnancies prior to the current one (parity)*: _____ If parity > 0 specify: _____

Spontaneous births 16-30 w: _____ Spontaneous births 31-36 w: _____ Spontaneous births after 37 w: _____

☐ Single pregnancy	☐ Twin pregnancy ☐ Vanishing twin	☐ Bicornal/biamniotic ☐ Monochorial/biamniotic ☐ Monochorial/monoamniotic
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Soft markers:

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

PHYSICIAN/ LABORATORY (According to Eurofins Genoma information sheet)

PATIENT - Online (Fill in data below)

Invoice

Report

☐☐☐☐

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 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 (SERUM)	☐ Amniotic Fluid	Date and time: _____
☐ Blood (EDTA) n° _____	☐ CVS	Signature (Abbreviation): _____
☐ Blood (HEPARIN) n° _____	☐ Semen	_____
☐ Other (<i>Specify</i>) _____ n° _____		

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