BIOANALYSIS
CLINICAL LAB

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Molecular and Genetic *Referral Form*

PATIENT DETAILS

Name:_____ Surname: _____ D.O.B.: ___/___/_____ I.D. No.: _____ Nationality: _____

Gender: ☐ Male ☐ Female Int No.: _____ ☐ GESY, ☐ Private, Address: _____ City: _____

Code _____ Country: _____ Phone: Home: _____ Work: _____ Fax: _____ e-mail: _____

REFERRING CLINICIAN / SCIENTIST / CLINIC / LABORATORY DETAILS

Name:_____ Surname: _____ Hospital / Clinic / Lab: _____

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 ☐ SWAP ☐ URINE
Other (please specify):_____

☐ First Investigation ☐ Repetition

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

TEST REQUEST *(Please tick ☑ accordingly)*

Cystic Fibrosis (CF) (FRAGMENT ANALYSIS):
- ☐ CF full mutation analysis (29 mutations)
- ☐ CF analysis for known mutation
- ☐ CF prenatal diagnosis

Haemochromatosis (RESTRICTION DIGEST):
- ☐ HFE C282Y & H63Dmutations

Hypercholesterolemia (SANGER SEQUENCING):
- ☐ LDLR - Hypercholesterolemia analysis

Lactose Intolerance (PCR):
- ☐ MCM6 - poly T-13910C

FAST PCR (RT-PCR):
- ☐ HPV - human papillomavirus
- ☐ CT & NG - Chlamydia and Gonorrhea
- ☐ TV – Trichomonas vaginalis
- ☐ CT & NG - Chlamydia and Gonorrhea
- ☐ GBS - Group B Streptococcus
- ☐ HCV Viral Load
- ☐ HBV Viral Load
- ☐ HIV Viral Load
- ☐ HIV Qualitative
- ☐ **Other DNA analysis upon request:** _____
- ☐ **DNA extraction/storage**

Hereditary Recurrent Fevers (HRFs) (SANGER SEQUENCING):

FMF
- ☐ MEFV full mutation analysis (Exons 2, 3, 5 & 10)
- ☐ MEFV analysis for known mutation

MVK
- ☐ MKD full mutation analysis (Exons 8, 9 & 10)
- ☐ MKD analysis for known mutation

TRAPS
- ☐ *TNFRSF1A* full mutation analysis (Exons 2, 3 & 4)
- ☐ *TNFRSF1A* analysis for known mutation

CAPS
- ☐ *NLRP3* full mutation analysis (Exon 3)
- ☐ *NLRP3* analysis for known mutation

Multiplexing for Pathogens (RT-PCR):

☐ **Respiratory** Adenovirus, Bocavirus, Coronavirus 229E, Coronavirus HKU1, Coronavirus NL63, Coronavirus OC43, human Metapneumovirus A/B, Influenza A, Influenza A subtype H1N1/2009, Influenza A subtype H1, Influenza A subtype H3, Influenza B, Parainfluenza virus 1, Parainfluenza virus 2/3/4, Respiratory Syncytial virus A/B, Rhinovirus/Enterovirus, Bordetella pertussis, Legionella pneumophila, Mycoplasma pneumoniae

☐ **Gastrointestinal** Clostridium difficile toxin A/B, Enteroaggregative E.coli (EAEC), Enteroinvasive E.coli (EIEC)/Shigella, Enteropathogenic E.coli (EPEC), Enterotoxigenic E.coli (ETEC) lt/st, Pathogenic Campylobacter spp., (C.jejuni, C.upsaliensis, C.coli), Plesiomonas shigelloides, Salmonella, Shiga-like toxin producing E.coli (STEC) stx1/stx2 & O157:H7,Vibrio cholera, parahaemolyticus, vulnificus, Yersinia enterocolitica, Cyclospora cayetanensis, Cryptosporidium spp., Entamoeba histolytica, Giardia lamblia, Adenovirus F40/41, Astrovirus, Norovirus GI/GII, Rotavirus A, Sapovirus (I, II, IV, V)

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/Guardian Signature: _____