Cytology Test Request Form

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Packaging instructions: https://www.eurofins.ie/biomnis/our-services/pathology-transport/packaging-transportation-guidelines/

REQUESTING PHYSICIAN - PLEASE USE BLOCK CAPITALS

PLEASE SPECIFY THE NAME OF THE REQUESTING PHYSICIAN WHO WILL RECEIVE THE FINAL REPORT

PHYSICIAN NAME: _____ **CLINIC NAME:** _____

ADDRESS: _____

TELEPHONE NO.: _____ **FAX NO.:** _____

PATIENT DETAILS - PLEASE USE BLOCK CAPITALS

SURNAME: _____ **FORENAME:** _____

DATE OF BIRTH :__ __/__ __/__ __ __ __ **ADDRESS**_____

_____

CLINICAL DETAILS

Please include any signs and symptoms, previous abnormal cytology, diagnosis and treatment:

_____

_____

_____

_____

TESTS REQUESTED

PLEASE CHOOSE REQUIRED TESTS	PRICE	SELECT
Cervical Cytology (Thinprep PAP Test)	€35	☐
High Risk HPV (Human Papilloma Virus) DNA Test	€75	☐
Special Combo Offer –Cervical Cytology and High Risk HPV DNA combined tests	€100	☐

CLINICAL DETAILS

LMP: __ __ / __ __ / __ __ __ __

LAST SMEAR TEST: __ __/ __ __ / __ __ __ __

Menopausal	☐	Hysterectomy	☐	Irregular Bleeding	☐
Post Menopausal	☐	IUCD in situ	☐	Discharge	☐
Post-Natal	☐	O/C	☐	Suspicious Cervix	☐
Cervix Visualised	☐	5 Rotations	☐		

PLEASE PROVIDE DETAILS: _____

_____

Smear Taker Signature:

EUROFINS BIOMNIS USE ONLY

DATE OF TEST:

PAYMENT DETAILS

LASER CARD ☐ **CREDIT CARD** ☐ **CHEQUE** ☐ **TOTAL AMOUNT €** _____

CARDHOLDER NAME (CAPITALS): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **CVV:** ☐☐☐

CARD NUMBER: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **CARD EXIPY DATE:** ☐☐ / ☐☐

CARDHOLDER PHONE NO.: _____ **CARDHOLDER SIGNATURE:** _____

CLIENTS WHO DO NOT HOLD AN ACCOUNT WITH EUROFINS BIOMNIS MUST INCLUDE PAYMENT WITH SAMPLE