eurofins | Biomnis

Cytology Test Request Form

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Email: salesdept@eurofins.ie / Web: www.eurofins.ie/biomnis

Packaging instructions: https://www.eurofins.ie/eurofins-lablink/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**______________________________

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CLINICAL DETAILS

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

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TESTS REQUESTED

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

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