eurofins | Biomnis

Test Request Form
Anti-SARS-CoV-2 IgG

PATIENT DETAILS

First name(s): .....Surname: .....

Address: .....

.....

Tel.: |_|_|_| |_|_|_| |_|_|_|_| Date of birth: |_|_| |_|_| |_|_|_|_| Gender: ☐ F ☐ M

REQUESTING CLINICIAN

First name(s): ..... Surname: .....

Name of Clinic/Hospital: .....

Department/ward: .....

Address: .....

.....

Phone number and e-mail address are ESSENTIAL for rapid return of results:

Tel.: |_|_|_| |_|_|_| |_|_|_|_| Fax: |_|_|_| |_|_|_| |_|_|_|_|

Email address: .....

REQUEST TEST

Test Name	Test Code	Select
Anti-SARS-CoV-2 IgG	COV2G	☐

Sample required: Serum
Keep sample refrigerated during storage and transport (+2 ° / +8° C)

Date of sampling : |_|_| |_|_| |_|_|_|_|

CLINICAL DETAILS

- Time in days since onset of symptoms, if any: .....
- Time in days since RT-PCR test for SARS-CoV-2, if applicable: .....

REASON FOR TESTING - *Optional*

Positive sample history for SARS-CoV-2	☐ YES	☐ NO
Co-exposed patient	☐ YES	☐ NO
Recent trip abroad (< 14 days)	☐ YES	☐ NO
	If yes, please specify the country:	
Close contact with a confirmed case	☐ YES	☐ NO

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

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

CARDHOLDER NAME (IN CAPITALS): ..... **CVV:** ___ ___ ___

CARD NUMBER: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **CARD EXIPY DATE:** ___ ___ / ___ ___

CARDHOLDER PH NO.: ..... **CARDHOLDER SIGNATURE:** .....