

Molecular Diagnostics Request Report

Lab no: _____ Date Received: _____

Name: _____ Surname: _____

Address: _____

ID no: _____ Tel: _____

Date of Request: _____ Requested by: _____

Date of sampling: _____ Time of sampling: _____

Clinical Details: _____

Type of Sample: Whole Blood Swab Other _____

TESTS REQUESTED

Y-chromosome Microdeletions	<input type="checkbox"/>	Androgen Receptor	<input type="checkbox"/>
Hepatitis B Virus	<input type="checkbox"/>	Hepatitis C Virus	<input type="checkbox"/>
Beta Thalassaemia	<input type="checkbox"/>	Leishmania	<input type="checkbox"/>
Chlamydia trachomatis	<input type="checkbox"/>	Neisseria gonorrhoea	<input type="checkbox"/>
Human Papilloma Virus	<input type="checkbox"/>	ACTN3	<input type="checkbox"/>

(sign and date)

Form N^o: MBDFR035
Date of Issue: 01.01.2006
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Authorised by: Q-Mgr