

Claymon Biomnis Genetic Test Request Form



PATIENT DETAILS:

Surname: _____
 Forename: _____
 Date of Birth: ____/____/____ Sex: Male: Female
 Hospital/Clinic No: _____
 Laboratory No.: _____
 Ward: _____
 Physician: _____
 Clinical Details (Including Any Family History):

REQUESTING HOSPITAL/CLINIC DETAILS:

Hospital/Clinic Name: _____
 Department: _____
 Address: _____

 Phone: _____ Fax: _____

PLEASE REMEMBER TO ALWAYS ATTACH THE RELEVANT INFORMED GENETIC CONSENT FORM

GENETIC PROFILES:

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