



Laboratory Genetic Metabolic Diseases
Test request form Metabolite / Tumor diagnostics



Accr.Nr: 157
ENISO 15189

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To assure correct handling of your request, please fill out this form completely (Grey fields are mandatory) and send it in together with the sample(s).

Patient information

Family name :
 First name :
 Date of birth : Day: Month: Year:
 Sex : Male/Female

Requested test(s) (see www.labgmd.nl)

Disease and/or analysis :

Material*

For metabolic screening always at least send urine and EDTA blood

							yes	no		
<input type="checkbox"/>	Urine	collection date.....	collection period.....	hrs	volume.....	ml	crisis	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Blood	sampling date.....	time.....	<input type="checkbox"/>	heparin	<input type="checkbox"/>	EDTA	deproteinized	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Plasma	sampling date.....	time.....	<input type="checkbox"/>	heparin	<input type="checkbox"/>	EDTA			
<input type="checkbox"/>	Serum	sampling date.....	time.....							
<input type="checkbox"/>	Bloodspot	sampling date.....	time.....							
<input type="checkbox"/>	CSF	sampling date.....	time.....				deproteinized	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	sampling date.....	time.....							
<input type="checkbox"/>	Tissue	sampling date.....	specify.....							

*Please send urine, plasma, CSF and tissues on dry ice, whole blood at ambient temperature, all by courier.

Relevant clinical and laboratory findings and medication

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Results should be sent to

Name :
Department :
Hospital/institute :
Address :
City and Zip-code :
Country :
Phone :
Fax :
E-mail* :

** Results will be sent per email when fax is unavailable, unless disagreed.*

No

Copy results should be sent to

Name :
Department :
Hospital/institute :
Address :
City and Zip-code :
Country :
Phone :
Fax :
E-mail :

Invoice should be sent to*

Name :
In case of institution :
 Department :
 Hospital/institute :
Address :
City and Zip-code :
Country :

** For EU countries only: Original S2 forms (formerly E 112) should be filled out completely and can be sent in together with the sample(s) or separately.*

Form completed by

Name :
Function/Department :
Date :
Signature :

Please note that without the above requested information the requested test(s) cannot be performed.

Use this as address label

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The Netherlands



**BIOLOGICAL SUBSTANCE
CATEGORY B**

DIAGNOSTISCH MATERIAAL

SPOED!



INSTRUCTIONS

- Please use the test request form that applies:
 - 1) metabolite/tumor-, 2) enzyme-, 3) DNA-diagnostics.
See www.labgmd.nl/forms
- To assure correct handling of your request, please fill out the test request form completely **in English** and send it together with the sample(s). Grey fields are mandatory.
- Please include copies of all relevant correspondence with our laboratory concerning the request.
- In case of urgent requests (e.g. prenatal testing) please contact a staff member of the laboratory BEFORE sending the sample.
- Our laboratory is open on working days Monday to Friday from 8.30 AM to 5.00 PM. Our website www.labgmd.nl lists national holidays on which our laboratory is closed.
- Please make sure that sample(s) arrive on Monday to Thursday before 3 PM, on Friday and the day before a public holiday before 12 AM. Otherwise we cannot guarantee that we can process the samples appropriately.
- For test-specific information about material/shipment please visit our website www.labgmd.nl