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Mod. PR 11 J1 ENG rev.02

Protocol Number (Internal use only):____________________

BabyNEXT samples acceptance sheet

Date: _________________________

INFORMATION ABOUT THE PATIENT

Name: ___________________________________ **Surname** ____

Date of birth: __________________________ **Place of birth:** ____

Address: ____ **Date of the collection:** ____________________________

Indications to the exam / clinical signs: ____

____

WHO REQUEST THE TEST

Specify the degree of kinship: ________________________

Name: _________________________ **Surname** ____________________________________ **Tel** _______________________

BIOLOGICAL SAMPLE TYPE

Buccal Swab ☐

TEST REQUESTED (check the corresponding box)

BabyNEXT STANDARD ☐ **BabyNEXT EXTENDED** ☐

REPORTING METHOD (check the corresponding box/boxes)

☐ **Doctor / Doctor's office / Laboratory** (according to EUROFINS GENOMA information sheet) ☐ **Parent**

☐ **E-mail:** ____

I, the undersigned ____ hereby authorize in accordance with Regulation EU 679/2016 to the sending of the report in the manner indicated above. to activate the online reporting it is mandatory to provide a username and password to be indicated below:

Username (**use your e-mail address**): ____

Password: ____ **Signature**: ____

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In accordance with Regulation EU 679/2016 I authorize EUROFINS GENOMA laboratory to the processing of my personal and sensitive data, for the purposes indicated above (complete information available on request).

Signature: ____________________________________

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