ALEX®
Allergy Explorer Panel
Test Request Form

PLEASE USE CAPITAL LETTERS TO FILL IN THE FORM

PATIENT DETAILS

First Name: _____ **Surname:** _____

Address: _____

Date of Birth: __ __ /__ __ / __ __ __ __ **Gender:** **Female** ☐ **Male** ☐

REQUESTING PHYSICIAN

Physician Name: _____

Clinic Name: _____

Address: _____

_____

Telephone Number: _____ **Fax Number:** _____

TEST REQUESTED

Test Name	Test Code	Select
ALEX® Allergy Explorer Panel	ALEX	☐

SAMPLE DETAILS

Sample required: 1mL serum refrigerated

Date sample was taken: __ __ /__ __ / __ __ __ __ **Time sample was taken:** __ __: __ __

IMPORTANT INFORMATION

PLEASE NOTE THAT TO RECEIVE YOUR PATIENT'S TEST RESULTS, YOU NEED TO HAVE AN ACCOUNT WITH EUROFINS BIOMNIS.

IF YOU DO NOT HAVE AN ACCOUNT WITH EUROFINS BIOMNIS, PLEASE CONTACT MARKETING@CTIE.EUROFINSEU.COM TO CREATE ONE.

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